Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene for State Registrar Certificate of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month 104 33 BABY HENRY T_M GIRI Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death URR 5 CROSS HOSPITAI PR JW. MONTGOM ER If Under 24 Hrs. Hours Min 8. Date of Birth (Month, Day, Year) 5. Social Security Number Age (In yrs. last birthday) If Under 1 Year g. Birthplace (State or Foreign **Funeral** 1 🗆 M 2 🗽 Months Davs Country) am Director Usual Residence of Decedent show 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits aţ within 72 hours after death with the Maryland Director r 28a-f sh notified a 1 ☑ Yes 2 ☐ No -HARL WALDORF MD 10g. Citizen of What Country? 10e. Street and Number 10f Zip Code ö ems 23a or must be r Funeral 6418 300 ARM 20602 SA items 11. Marital Status 12 Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14 Bace - American Indian er than "natural", or iter the Medical Examiner Armed Forces? If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. 1 Never Married 2 Married þ Maryland 21215-0036 1 ☐ Yes 2 No Specify: If Yes, Give Year or Dates Specify: 3 Widowed 4 Divorced Completed BLACK 15. Decedent's Education (Specify only highest grade completed) Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life, DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Hygiene. PURAUT INFAN 11 permit. Page 1 and 2 should be filed wir Department of Health and Mental Hygie Important: If item 27 is marked other any injury or other traumatic event, it Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) မ HENR UNK ANA 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 20910 CROSS HOSPITAI FOREST HOLY (OLEN) 1200 Baltimore, 20a, Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other place) ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 □ Donation 5 🛛 Other (Specify) in state Signature of Euneral Service Licensee Ronald S. Wade ²² State Anatomy Board 655 W. Baltimore Street Baltimore. 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ HABONOLEM SHOCK disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner LMONARY HYPOPLACI MVS Sequentially list conditions, Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Due to (or as a consequence of) PPROM the Hospital or Attending Physician: The law requires that the death certificate be executed burial-transit WKS and Due to (or as a consequence of): resulting in death) Last attending physician for use as the buria Physician/Medical XTREME 28WKS GEST PREMATURIT Division of Vital Records, P.O. Box 68760 IF FEMALE: be detached for use 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy
5 Other (specify) in the past 12 months? Month Dav Year 4 Pregnant at time of death g Unknown 2 No the 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown page 2 should peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performed' After this certificate 2 🗌 No Yes Yes 2 N completed filled in by the funeral director, 25. Was case referred to medical 8 B 26. Place of Death (Check only one) Hospital 2 No 1 Yes မ 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 Natural work 5 Pending s after death. 1 Yes 2 No Accident Investigation 6 Could not be Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 - Homicide determined 24 hours Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check within 2 3 🗌 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one) title of certifie 3509 2002 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) TANKT RD MD 1200 FOREST GLEN 31. Date filed (Month, Day, Year) Registrar's Signature State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month 94 Physician/ 2150 Phelton Hall Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death Union Memorial Hospital Baltimore 5. Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Days Hours Min. 1 🔀 M 2 🗆 F Months Feb 8, 1939 Country) Director 267-56-3015 72 Usual Residence of Decedent 28a-f shov 10b. County 10c. City, Town or Location 10d. Inside City Limits notified at Director 1

Yes 2 □ No MD Baltimore 10e. Street and Number 10f. Zip Code ò 10g. Citizen of What Country? must be Funeral 23a 21209 4669 Falls Road USA 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) "natural", or iten ledical Examiner r 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian Armed Forces? Black, White, etc. ģ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 If Yes Give 1 ☐ Yes 2 X No Specify: white 3 X Widowed 4 □ Divorced Completed Year or Dates un 15. Decedent's Education 16a. Decedent's Usual Occupation un 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working Il Hygiene. College (1-4 or 5+) life. DO NOT use retired) Elementary/Seconday (0-12) the Be unk 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Health and Mental tem 27 is marked c ည and 2 should be 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Union Memorial Hospital 201 E. University Pkwy Baltimore, MD 21218 t of Heal 20a, Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Page 1 ō 1 Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 X Other (Specify) in state 21. Signature of Funeral Service Lice Roma Ld S 23a. Part 1. Inter the disease, in complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, on reart failure. List only one cause on each line.

Immediate Caus Final disease or condition resulting in death)

a. RSA 22 Name and Address of Facility Board 655 W. Baltimore Street Approximate Interval Between Onset and Death **∜**Physician/ days Medical Examiner days neumonio Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of Sepsis Exami attending physician and for use as the burial-transit Cause (Disease or iinjury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) this certificate has been signed by the atteral director, page 2 should be detached for in the past 12 months? Month Dav Year Pregnant at time of death 9 Unknown P.0. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Division of Vital Records, 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy performed' death? 1 ☐ Yes 2 ☐ No 2 🔽 Yes To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certific completed filled in by the funeral director, 25. Was case referred to medical To Be 26. Place of Death (Check only one) examiner? Other: 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred 1 Natural injury 5 Pending 1 ☐ Yes 2 ☐ No Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one) 3 29b. Signature and title of certifier 29d. Date signed (Month. Day, Year)

Registrar

State

Maria

31. Date filed (Month, Day, Year)

E. University

201

2. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

AT 2438946

84

04/05/11

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend #3 Per PHY G914 4/21/2011 JH State of Maryland / Department of Health and Mental Hygiene OF THE STATE OF State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2 Date of Death Aprel 9, 2011 Year 4:30 TA M Dominic Iervello Physician/ Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Baltimore** 4c. County of Death **Examiner** Alice Manor Nursing Home 9. Birthplace (State or Foreign If Under 1 Year If Under 24 Hrs. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8 Date of Birth **Funeral** Days Hours Min. **XX** M 2 □ F Months July 23, 1913 97 215-10-1056 Yrs Director Usual Residence of Decedent or 28a-f show notified at permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show amy injury or other traumatic event, the Medical Examiner must be notified at one. 10b. County 10c. City, Town or Location 10d, Inside City Limits 10a. State Director 1 XXYes 2 □ No N/A Baltimore MD 10f. Zip Code 10g, Citizen of What Country? 10e. Street and Number Funeral U.S.A. 21211 2095 Rockrose Avenue 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 Yo Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11 Marital Status Black, White, etc. þ 1 Never Married 2 Married 1 Yes If Yes, Give Baltimore, Maryland 21215-0036 1 Yes 2 XX Specify: Specify: White 3 XXidowed 4 Divorced Completed Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) T.I. Schwartz Tailor Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 Filomena DiFranscesca John Iervello 19a. Informant's Name/Relationship (Type, Print) **Phyllis A. Iervello (Daughter)** 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Apt. 101 Timonium, MD 21093 6 Brooking Ct. 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 1 Surial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) Timonium, MD Dulaney Valley 4/13/11 22. Name and Address of Facility.

Lemmon Funeral Home of Dulaney Valley, Inc.
10 West Padonia Road Timonium, MD 21093 ature of Funeral Service 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final Physician/ Chronie disease or condition resulting in death)) Medical Due to (or as a consequence of) Examiner eneration Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of) Early Deme Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or linjury attending physician and for use as the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day Year Pregnant at time of death 5 Other (specify) Yes 2 Unknown been signed by the sahould be detached a I Inknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Braem 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 1 Tes 24b. Were autopsy findings available prior to completion of cause of death? hearny deregre 24a. Was an cate has ; page 2 s autopsy performed? Yes 2 No 1 Yes 2 No After this certificate the funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) ည 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: injury 1 Natural 5 Pending 1 🔲 Yes 2 🗌 No Investigation Accident after death Director: / 3 ☐ Suicide 4 ☐ Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by determined 24 hours a Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a, Certifier сотріете Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check 3 🗌 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. within 2 To the I only one) 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifie D 31464 MD 4/13/11 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) EYTAW IT frite 310 BALTIMORT MD 2120

DHMH 17 Rev 7/2009

State Registrar SHOAIB.A. HASHMI

821 N.

MD

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month 9:00 PM **Physician** ZOIL sharon Jones /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number 4b. City, Town, or Location of Death Examiner Johns Hopkins Bayview Medical Center **Baltimore** N/A 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 6. Sex 7. Age (In vrs. last birthday) 5. Social Security Number **Funeral** 1 □ M 2 🖁 F Days 55 /29/1956 Director 212-76-9887 MD Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland 10d. Inside City Limits 10a State 10b County 10c. City. Town or Location show 1 Yes 2 No Director MD N/A Baltimore 28a-f Examiner must be notified 10g. Citizen of What Country? 10e. Street and Number 10f. Zip-Code ò 21224 USA 224 Douglas Ct. or items 23a Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 【XNo If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status 1 Never Married 2 Married 1 ☐ Yes 2 XNo Baltimore, Maryland 21215-0036 Specify. Specify: Black ≥ 3 Widowed 4 □ Divorced "natural", Completed 16b. Kind of Business/Industry 16a, Decedent's Usual Occupation traumatic event, the Medical 15. Decedent's Education (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) and Mental Hygiene. Is marked other than Disabled Disabled 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Geraldine Cole မ Joseph Jackson 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) permit. Pages 1 and 2: Department of Health at Important: If Item 27 Is any Injury or other trau Kristin Jones-Daughter 2326 Orleans Street Balto., MD 21224 20b. Place of Disposition (Name of cemetery, crematory or other place)
King Mem. Park 20c. Location - City or Town, State 20a. Method of Disposition 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State King 4/16/2011 Randallstown, 4 Donation 5 Other (Specify) 21. Signature of Funeral Se de License 22. Name and Address of Facility March F/H 1101 E. North Branfi Millan Ave. Baltimore, MD 21202 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arreshock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final ruseless Electrica Physician disease or condition resulting in death) /Medical Due to (or as a consequence of): 3 weeks Examiner Sequentially list conditions, if any, isaling to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examine Due to for es a consequence of attending physician and I for use as the burial-transit The law requires that the death certificate be executed resulting in death) Last Due to (or as a consequence of): Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant Live birth 2 Fetal death 3 Tectopic pregnancy Month Day in the past 12 months?
1 Yes 2 No Pregnant at time of death 5 Other (specify) n signed by the att Division of Vital Records, P.O. 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. \$ 2 No 3 Probably 1 ☐ Yes page 2 should Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy has 2 🗌 No 1 TYes Yes 2 this certificate Physician: completely filled in by the funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA 1 🗌 Yes မ 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Deat Certification: al or Attending F s after death. After Injury 1 Natural 2 Accident Natural 5 Pending 1 🗌 Yes 2 🗌 No investigation Director: 3 🗌 Suicide 6 Could not be 28f. Location (Street and Number or Rural Route Number, 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) determined City or Town, State) 4 Homicide To the Hospital o within 24 hours af To the Funeral Di Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (check only Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) one) and manner stated 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier 10,2011 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 4940 Eastern Avenue, Baltimore, MD, 21224 onerman Matthew 31. Date filed (Month, Day, Year) State back

DHMH 17 Rev 1/2001 11595

Registrar

31. Date filed (Month, Day, Year)
APR 1 4 2011

0.0

Franklin Square Drive Baltimore, MD 21237

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DOC

32. Registrar's Signature

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiers State Certificate of Death Registrar Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ JOSEPH WALTER **JOSKA** APRIL 10 2011 10:45pM Medical **Examiner** 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death STELLA MARIS HOSPICE TOWSON BALTIMORE Social Security Number If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign . Age (In yrs. last birthday) 8. Date of Birth **Funeral** Days 1 🔀 M 2 🗌 Hours Min. 12/23/1921 **Director** 212127447 89 MARYLAND Usual Residence of Decedent item 27 is marked other than "natural", or items 23a or 28a-f shov other traumatic event, the Medical Examiner must be notified at 10b. County 10c. City, Town or Location Funeral Director 10d. Inside City Limits BALTIMORE MD ROSEDALE 1 🗆 Yes 2 🔀 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1212 RUSTIC AVENUE 21237 USA 12. Was Decedent Ever in U.S Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Armed Forces?

1 X Yes 2 No Black, White, etc <u>}</u> 1 Never Married 2 Married 1 ☐ Yes 2 🔀 No Specify: Specify: WHITE 3 XWidowed 4 ☐ Divorced Completed WW II Year or Dates. 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) MEAT PACKER **ESSKAY** Be 17. Father's Name (First, Middle, Last) should be file and Mental F. is marked of 18. Mother's Name (First, Middle, Maiden Surname) LOUIS JOSKA BERTHA OLSZEWSKI permit. Page 1 and 2 should be Department of Health and Meni Important: If item 27 is marke any injury or other traumatic once. 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) MARY SHAY-CONOVER/DAUGHTER 1212 RUSTIC AVE BALTIMORE, MD 21237 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place 20c. Location - City or Town, State Date 1 X Burial 2 Cremation 3 Removal from State GARDENS OF FAITH 04/14/11 BALTIMORE, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Fynetal Service Licensee 22. Name and Address of Facility CVACH / ROSEDALE FUNERAL HOME 1211 CHESACO AVE BALTIMORE, MD21237 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Onset and Death h sician/ OBSTRUCTIVE PTRDNIC disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to for as a consequence on or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of) by Physician/Medical al Records, P.O. Box 68760 IF FEMALE: yes, outcome of pregnancy
Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?
1 ☐ Yes 2 ☐ No Pregnant at time of death Month Day Year 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed 2 No 3 ☐ Probably 4 ☐ Unknown . Were autopsy findings available prior to completion of cause of 24a. Was an autopsy death? 1 🗌 Yes Yes 25. Was case referred to medical Certificate: To Be 26. Place of Death (Check only one) examiner? 1 Yes 2 Other: Mospice 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury 1 Natural
2 Accident
3 Suicide 5 Pending injury 1 ☐ Yes 2 ☐ No Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 🗌 Homicide 28f. Location (Street and Number or Rural Route Number, determined City or Town, State the Hospital within 24 hours To the Funeral Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one 29b. Signature and title of certifier 29d. Date signed (Month, Dav. Year) who completed cause of death (Item 23a) (Type, Print) 300 State Registrar

	Please Type or Print in Black Indelible Ink, Ensure All Copies Are Legible. AMEND TITEM#5perFH,G914,4/2//2011,WS State of Maryland / Department of Health and Mental Hygiene											
		-	For State Registrar	State of Maryland / t	Certificate of			Reg. N2. 0 1 1 1 2 0 0 7				
	Physicia	n/	1. Decedent's Name (First, Middle, Last)	live			2. Date of Death Month	3. Time of Death				
-	Medic	al	4a. Facility Name (if not institution, give stre	eet and number)	4b. City, Town,	or Location of Death	Apri'l	Day Year 4c. County of Death				
	, 		3712 Nortonia Kol Baltimae NI									
	Funeral Director		220 18 4352 101	403	Yrs. Months Days		8. Date of Birth (Month, Day, Ye.	917 000	ntry) MD			
	show d at	to	Usual Residence of Decedent 10a. State 10b. County			10d. Inside City Limits						
	e Mary r 28a-f notifie	Director	MD NA	B	altimo	re	100	. Citizen of What Cou	1 Nes 2 No			
	within 72 hours after death with the Maryland glene. er than "natural", or items 23a or 28a-f sho er than Medical Examiner must be notified at the Medical Examiner	Funeral	3712 Norto	inia Kol	- 6	21216		USA				
	or item	by Fur	11. Marital Status 12 1 Never Married 2 Married	. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 O	If Yes, specify Cu	Hispanic Origin? (Spe ban, Mexican, Puerto	cify Yes or No- Rican, etc.)	14. Race - Amer Black, White				
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	d within dygiene ther th nt, the	Be Co	17. Father's Name (First, Middle, Last)	- Conlege (1 + Gr o.)	NI	18 Mather's Name	e (First, Middle, Maid	den Surname)	4			
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Maryland	ge 1 and 2 should be filed within 72 hours after death with the Maryland tt of Health and Mental Hygiene. If item 27 is marked other than "natural", or items 23a or 28a-f show or other traumatic event, the Medical Examiner must be notified at		19a. Informant's Name/Relationship (Type,	roll 19h	. Mailing Address (Stree	et and Number or Rura	0:	y or Town, State, Zip Ra Hmi	() [
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Baltimore,	Pa ant ant		4 Donation 5 Other (Specify) 21. Signature of Funer Service Live ee	Arbi	22. Name and Add	ross of Eacility 11	13/204	Baltin	De, MD			
Ba	permit. Departr Imports any inju	0. 3	21. Signature of Funer Cice Livree	forced Se.	4600 L	berty	Heigh	is Ave.	Batto. MD			
			23a. Part 1. Enter the disease, or complice shock, or heart failure. List only one of Immediate Cause (Final	ations that caused the death. Do r cause on each line.	not enter the mode of dy	ying, such as cardiac o	or respiratory arrest,		Approximate Interval Between Onset and Death			
đ	hysician/ Medical		disease or condition resulting in death)	Tue to (or as consequence	Ve +80	irt ta	Mure	-				
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68760	ath certificate be ex attending physician for use as the burial	Medi	IE EEMALE:									
Box 6	ath cer attendi I for use	Physician/Medica	23b. Was decedent pregrant in the past 12 months? 1 Yes 2 No	 If yes, outcome of pregnancy 1 ☐ Live Birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 	h 3 Ectopic pregna 5 Other (specify)			ivery Day Year				
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S, P.	uires than signed	ed by	Tartin Guidi digililida k danah da a				1 □ Yes	. /	robably 4 🗌 Unknown			
Records,	law requals been as been as been as been as a should be a should b	Completed					24a. Was an autopsy performe	prior to d	topsy findings available completion of cause of			
II Re	n: The lificate h		25. Was case referred to _ edical		26.	Place of Death (Chec	1 Yes 2		2 No			
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n of	ding Pl th. After th funeral	cate:	27. Manne f Death 1 atural 5 Pending 2 Accident Investigation			jury at ork? □ Yes 2 □ No	28d. Describe how	injury occurred				
Division of Vital	r Atten ter dea irector: n by the	Certificate:	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - At home, fa building, etc. (Specify)	rm, street, factory, offic	е	28f. Location (Stree City or Town, S	et and Number or Ru State)	ral Route Number,			
Ö	To the Hospital or Attending Physician: The law requires that the death certificate be within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physici completed filled in by the funeral director, page 2 should be detached for use as the but	ical	29a. Certifier 1 Certifying Physici	an: To the best of my knowledge,	death occured at the tir	me, date and place, a	nd due to the cause	s) and manner as sta	ated.			
	the Ho hin 24 the Fu mpleted	Medical	only one) 3 Certifying Nurse I	r: On the basis of examination and/o Practioner: To the best of my know	ledge, death occurred at	inion, death occurred a the time, date and planse the number	ce, and due to the ca	blace, and due to the duse(s) and manner as	stated.			
	6 .≱ 6 .8		29b. Signature and title of certifier	Southall	110 14	0063	3236 A	JPN1	2 2011			
			30. Name and address of person who com	pleted cause of death (Item 23a)	(Type, Print)	Greens.	Shaat	Ratte	Wa MO 21201			
	Sta		31. Date filed (Month, Day, Year)	2. Registrar's Signature	booked	Crient.	Street	1 341.11	11 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1			
	Registr	ar	APK 14 ZUII	Kensur p. 1	A CALL							

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 2011 April 5, 8:55 pmM James Roma Marie Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death Arlington West Nursing HOme Baltimore 5. Social Security Number Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. **Funeral** 8. Date of Birth 9. Birthplace (State or Foreign 1 □ M 2 🖵 F Months Hours Nov 12, Year) 935 226-46-8790 75 Director Virginia Usual Residence of Decedent items 23a or 28a-f show ter must be notified at 10a. State 10b. County filed within 72 hours after death with the Maryland 10c. City, Town or Location Director 10d. Inside City Limits 1 🗓 Yes 2 🗌 No MD Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 3939 Penhurst Avenue 21215 USA 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No If Yes, Give ıral", or iten I Examiner r Was Decedent of Hispanic Origin? (Specify Yes or No-14. Race - American Indian If Yes, specify Cuban, Mexican, Puerto Rican, etc.; Black, White, etc. þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 Yes 2x No Specify: "natural", Completed 3 K Widowed 4 Divorced Specify: White Year or Dates other traumatic event, the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) I Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) 12 Homemaker Own Home Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) nd Mental F ၉ Charles William Clarence Bishop ed bluods Esta May Smallwood and l 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 st
Department of Health a
Important: If item 27 is
any injury or other tra Paula James Craze - Daughter 17304 Soper St. Poolesville, MD 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State 1 X Burial 2 Cremation 3 Removal from State cemetery, crematory or other place) 4-9-11 4 ☐ Donation 5 ☐ Other (Specify) Union Cemetery Leesburg, VA f Funeral Service Dicensee 22. Name and Address of Facility Colonial Funeral Home 201 Edwards Ferry Rd. Leesburg, Virginia 20176 and 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, lock or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition Onset and Death Physician/ Small Cell Cancer of Lung Medical resulting in death) Due to (or as a consequence of): Examiner Metastasis to Liver & Nodes Sequentially list conditions ll ary, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence by) Exami attending physician and for use as the burial-transit Jaundice that initiated events resulting in death) Last Due to (or as a consequence of)
Dehydration Physician/Medical or Attending Physician: The law requires that the death certificate be P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?

1 Yes 2 No 3 Ectopic pregnancy Day 4 ☐ Pregnant at time of death 9 ☐ Unknown 5 Other (specify) signed by the a Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? δ Division of Vital Records, Psychosis Completed 1X Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown ASCVD 24b. Were autopsy findings available 24a. Was an cate has page 2 s autopsy performed prior to completion of cause of certificate 1 ☐ Yes 2 ☐ No 1 Yes 2 No director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 2 🖰 No Other: ၉ 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify) this within 24 hours after death.

To the Funeral Director; After thi completed filled in by the funeral 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 X Natural injury 5 Pending 1 ☐ Yes 2 ☐ No Investigation 6 Could not be Accident Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Hospital Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one 29b. Signature and title of contifier 29c. License number 29d. Date signed (Month, Day, Year) death (Item 23a) Type, Print W-BALTIMORE 5/_ State Registrar

11-02799 Gail Lynn Jackson Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Sail Lynn Jackso		1- For State Registrar	tate of Marylar			of Health ar	nd Men	tal Hyg		20	And the second s	12009
Physicia	n/	Decedent's Name (First, Mide	ile,Last)						Date of Death			3. Time of Death
Medical Examin	ıer	Gail Lynn						A	Month April 12, 20	Day Y 11	/ear	1320 hrs
		4a. Facility Name (if not instituti 13 North Ritters Lane		ber)		4b. City, Town, o		of Death			ty of Death ore Cou	
Funeral		5. Social Security Number		. Age (In yrs. I	last birthday			er 24Hrs. 8	. Date of Birth			thplace (State or
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		Usual Residence of Decedent			_					J, 13.		
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death with the Maryland or items 23a or 28a-f she must be notified at once	Director					10f. Zip Code			100	, Citizen of \		•
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Baltimore, permit. Pages 1 a Department of the Important: If it injury in rither the	ŀ	4 Donation 5 Other S		Cre	emāŧģ	ry & Cha	pe1	4/14	/11	Mancl	nest	er, MD
Ba permi Depa Impo injur		4 Donation 5 Other Specify: Crematory & Chape 1 4/14/11 Manchester, M 21. Signature of Funeral Segrice Licensee										apel P.A.
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Box 6876(c death certificate the attending phyself for use as the b	cian/Me	23b. Was decedent pregnant in the past 12 months?	I L LIVE DILL	n t at time of de	ath	Fetal death 3	Ectopic	pregnancy		Month	D	ay Year
Box e death the atter ed for u	Physic	1 Yes 2 No 9 🗹 Uni	i lund		atn 5	Other (Specify)						
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Reco	E								perform 1 ✓ Yes 2		death? 1 ✓ Yes	s 2 No
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Investigation 2 Accident Investigation 28e Place of Injury - At home farm street factory office building etc. 28f Location (Street and Nu								eet and Num	ber or Rur	al Route Number, City		
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	Σ	29b. Signature and title of certifie	n 0.00			29c. Licens O.C.				9d. Date sig April 13, 2		th, Day, Year)
		fote () -	roll	t doeth (!	220)	0.0.	IVI. C.			א, בי וווער, ב	.011	
JO.		 Name and address of person Patricia Aronica-Pollal 		of death (Item : Medical E		111 Penn St	reet, Bal	itimore, N	1D 21201			
Stat	e	31. Date filed (Month, Day, Year)	32. Regis	trat's Signatu	re ,			·		•		

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene for State Registrar Certificate of Death Reg. No... 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month FLORINE ROBERTA JONES 6:29a 2011 APRIL Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** BALTIMORE DULANEY VALLEY STELLA MARIS HOSPICE CENTER 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Age (In yrs. last birthday) If Under 1 **Funeral** Days 1 □ M 2 🛣 F Months Hours 216-18-0457 91 Director 5-1920 MARYLAND Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location ortant: If item 27 is marked other than "natural", or items 23a or 28a-f sho injury or other traumatic event, the Medical Examiner must be notified at Director 1 X Yes 2 No N/A BALTIMORE MD. 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 1447 KITMORE RD. USA 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No If Yes, Give Year or Dates. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. ģ 1 Never Married 2 Married 21215-0036 1 ☐ Yes 2 🙀 No Specify. Specify: BLACK Completed 3X Widowed 4 □ Divorced Decedent's Education 16a. Decedent's Usual Occupation 16b Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed, Elementary/Seconday (0-12)
-12-College (1-4 or 5+) CLOTHING SALES Be Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည be f ADA JOHNSON JOHN R. BROWN SR. 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) CLARENCE 1303 CEDARCROFT RD. BALTIMORE, MARYLAND 21239 RANKIN(SON) Baltimore, 20a. Method of pisposition 20b. Place of Disposition (Name of 1 🕅 Buria 2 Cremation 3 Removal from State DULANÉY VALLEY CEM. 4-19-2011 TIMONIUM, MARYLAND 4 Don tion 5 other (Specify) HIBNER Name and Address of Facility PHILLIPS FUNERAL HOME, P.A. 21. Signature <u> 21-27 N. MONROE ST. BALTIMORE, MARÝLAND 21217</u> Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition Medical resulting in death) **Examiner** Sequentially list conditions, Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of) that initiated events Due to (or as a consequence of): resulting in death) Last signed by the attending physician by Physician/Medical Hospital or Attending Physician: The law requires that the death certificate be Box 68760 IF FEMALE 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?

1 Yes 2 No
9 Unknown Pregnant at time of death g Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, 2 No 3 Probably 4 Unknown 1 Yes Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performe After this certificate 2 No 1 Yes **Division of Vital** 25. Was case referred to medical Certificate: To Be 26. Place of Death (Check only one) examiner? Other: 2 X No 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred 5 Pending work? Natural Accident Investigation 24 hours after deat Funeral Director: Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check within 2 To the F only one 29b. Signature and title of son who completed cause of death (Item 284) (Type, 30. Name and ad State Registrar

DHMH 17 Rev 7/2009

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		1 - State Registrar	tate of Maryland		artment of H			giene Reg. No 2011	12012
Physici /Medic	cal	Decedent's Name (First, Middle, Last) TLOREN CE 4a. Facility Name (If not institution, give street)	et and number)		JASKU LS		2. Date of Dea Month AFRIL Death	Day Yea	5:11 1 M
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or 28	Director	10e. Street and Number		2111,1	10f. Zip-Code			10g. Citizen of What 0	Country?
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rs aft	by F	1 X Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates:	1	I∐Yes 2XX No	Specify:		Specify:	WHITE
I 3-UU30 n 72 hours after death with the Marylan "natural", or Items 23a or 28a-f show dical Examiner must be notified at		15. Decedent's Educat	on	16a. Deced	dent's Usual Occup	ation		16b. Kind of Busine	ss/Industry
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es 1 a of He		20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Rem		ace of Dispo	sition (Name of natory or other plac	- 1	Date	20c. Location - City	
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he lav e has age 2	Completed						—— autor perfo 1 ☐ Yes	osy prior ormed? death 2.2.5.No 1	
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hysici nis cer	5 E	1 les 2 Alvo	pital: 1. ■ Inpatient 2 □ E	R/Outpatien	t 3 □ DOA Oth	er: 4 🗆 Nur	sing Home 5 - Resid	dence 6 🗆 Other (S	pecify)
Ing Pl	io io	1. Natural 5 ☐ Pending	28a. Date of Injury (Month, Day Year)	28b. Time o Injury	Work	<?		how injury occurred	
death death stor: A	licat	2 Accident investigation 3 Suicide 6 Could not be	28e. Place of injury - At hom	ne. farm. stre	-	Yes 2 ☐ N		Street and Number o	r Rural Route Number,
lor A after Direct din by	Certification:	4 ☐ Homicide determined	building, etc. (Specify)		oo, ractory, omeo		City or Tov		, may a modern promise of
ospita hours ineral		29a. Certifier (check only 2 Medical Examiner	an: To the best of my know	edge, death	occurred at the tir	ne, date and	d place, and due to the	cause(s) and manne	r as stated.
To the Hospital or Attending Physician: The law requires that the death certifical within 24 hours after death. Within 24 hours after death. The Funeral Director: After this certificate has been signed by the attending phy completely filled in by the funeral director, page 2 should be detached for use as the complete of the funeral director, page 2 should be detached for use as the complete of the funeral director.	edical	one)	On the basis of examination and manner stated.	on and/or in	vestigation, in my o	pinion, deal	tn occurred at the time	, date and place, and	due to the cause(s)
To t	Σ	29b. Signature and title of certifier			29c. License			29d. Date signed (Mo	
		8/m 209				-00	C	APRIL 11	2011
		30. Name and address of person who comp				49	40 Eastern Δ	venue. Baltir	nore, MD, 21224
Sta	ate	31. Date filed (Month, Day, Year)	32 Registrar's Signatu	re /					
Regist	rar	APR 1 4 2011	32 Registrar's Signatu	ga	iti				

DHMH 17 Rev 1/2001 11595

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Day Physician/ 6:55 P. M Katherine M. Krieg 10 201 April Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Anne Arundel Morningside House of Friendship Hanover Social Security Number 6. Sex If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Days 1 🗆 M 2 🕱 I Hours 10/13/1909 Mary Land 101 **Director** 215 30 3386 Usual Residence of Decedent item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at should be filed within 72 hours after death with the Maryland nand Mental Hyglene. • is marked other than "natural", or items 23a or 28a-1 show 10b. County 10d. Inside City Limits 10a. State 10c. City, Town or Location Director Anne Arundel Hanover 1 🗌 Yes 2 🏝 No Maryland 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21076 U.S.A. 7548 Old Telegraph Road Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. Black, White, etc. Armed Forces Completed by 1 Never Married 2 Married ☐ Yes 2 K No Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🛣 No Specify: If Yes, Give Specify: 3 X Widowed 4 Divorced White Year or Dates 15 Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) College (1-4 or 5+) Elementary/Seconday (0-12) Own Home Homemaker 8th Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) William Vogel Mary Ellen Beswick 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) permit. Page 1 and 2 st Department of Health a Important: If item 27 is any injury or other tra Baltimore, Maryland 21225 Margaret Krieg Allman / Daughter 654 Sunset Strip 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State ■ Burial 2 ☐ Cremation 3 ☐ Removal from State Baltimore, Maryland 04/14/2011 4 ☐ Donation 5 ☐ Other (Specify) Cedar Hill Cemetery 22. Name and Address of Facility . Si atur of Funeral Service Licensee Gonce Funeral Service, P.A. 4001 Ritchie Highway Baltimore, Maryland 21225 omplications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, 23a. Part 1. Enter the diseas Approximate shock, or heart failure. List nly one cause on each line. Interval Between set and Death Immediate Cause (Final Priysician/ once! disease or condition resulting in death) Medical Due to (r as a consequence of **Examiner** Sequentially list conditions, Examiner cause. Enter Underlying Cause (Disease or iinjury Due to for as a consequence of or Attending Physician: The law requires that the death certificate be executed been signed by the attending physician and should be detached for use as the burial-tranthat initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months? Month Day Pregnant at time of death Yes 2 No 9 Unknown Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 Abo 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an within 24 hours after death.

To the Funeral Director. After this certificate has completed filled in by the funeral director, page 2. After this certificate has autopsy perform 1 Yes 2 Wo 25. Was case referred to medical 26. Place of Death (Check only one) Be Other: 4 \(\) Nursing Home 5 \(\) Residence 6 \(\) Other (Spec Hospital 1 Yes 2 No ျှ 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: 1 Aatural 5 Pending 1 🗆 Yes 2 🗆 No Accident Investigation 2 Accider
3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check 3 🗆 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifie 29c. License number of death (Item 23a) (Type, 210 31. Date filed (Month, Day, Year) State Registrar

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No... 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ APRIL 2011 MARIE LOUISE LOCKHART 7:35A Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death OVERLEA HEALTH & REHAB BALTIMORE CITY BALTIMORE Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 8. Date of Birth 1 M 2 K MF Months Hours Director 216-16-8522 87 Yrs. 1924 Marvland Feb. Usual Residence of Decedent "natural", or items 23a or 28a-f show 10b. County Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits Director Maryland Baltimore Baltimore County 1 Yes 2XXNo 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Completed by Funeral 200 Sipple Avenue 21236 USA permit. Page 1 and 2 should be filed within 72 hours after death Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces?
1 ☐ Yes 2XX No Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 Yes 2 X No Specify: 3 X Widowed 4 Divorced Specify White event, the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) 12th grade N/A Clerk Retail Sales Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ဂ္ William Dean Margaret Lohrey 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Marcinda Fast (Daughter) 200 Sipple Avenue Baltimore, Md. 21236 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date XX Burial 2 ☐ Cremation 3 ☐ Removal from State Gardens of Faith 4-16-2011 Baltimore, Md. 4 Donation 5 Other (Specify) Signature of Funeral Service Licensee ^{22. Name and Address of Facility} Lassahn Funeral Home 7401 Belair Rd. Balt eather 21236 <u>Baltimore</u> Maryland 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line Interval Between Immediate Cause (Final Onset and Death Physician/ DEMENTIA disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of) that the death certificate be executed Jause (Disease or illiniur) attending physician and for use as the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No
9 Unknown Month Other (specify) Day Year Pregnant at time of death g Unknown sate has been signed by page 2 should be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? <u>6</u> Completed 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a. Was an autopsy performed Yes 2 No funeral director, Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? 2 No မ 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at work?
1 Yes To the Hospital or Attending F within 24 hours after death. To the Funeral Director; After it 28d. Describe how injury occurred Natural injury 5 Pending 2 🗌 No Investigation
6 Could not be Accident Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, Medical 29a. Certifie Certitying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Cereffying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one 29b. Signature and title of certifier 00060520 30. Name and address of person who completed dause of death (Item 23a) (Type, Print) KHETERPAI 9106 PHILADEL 31. Date filed (Month, Day, Year) State

Registrar

4 2011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. De dent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 2011 300 M GUL Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Anne Arundel Tate Hospice House Linthicum If Under 1 Year If Under 24 Hrs. Social Security Number Birthplace (State or Foreign Country)
 PA Age (In yrs. last birthday) 8. Date of Birth **Funeral** NOV. Ze rear 1930 Days Hours Min 1 □ M 2 XF 80 202-24-6398 Director Yrs. Usual Residence of Decedent r than "natural", or items 23a or 28a-f shov the Medical Examiner must be notified at hours after death with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2XXNo MD Anne Arundel Laurel 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 359 Dameron S. 20724 U.S.A. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian Armed Forces? Black, White, etc. ģ 1 Never Married 2 Married Maryland 21215-0036 If Yes, Give Year or Dates 1 Yes 2 XXo Specify Specify: 3 XWidowed 4 Divorced White Completed 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) should be filed within 72 h and Mental Hygiene. 7 is marked other than "r within 72 Elementary/Seconday (0-12) Grade 12 College (1-4 or 5+) Homemaker Own Home Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Pierce Walinsky Nellie Galinsky permit. Page 1 and 2 should I Department of Health and Me Important: If item 27 is mark 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 5208 N. 11th Street Victoria Lyons daughter Arlington, VA Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date injury or 1 XXBurial 2 Cremation 3 Removal from State Meadowridge Mem Pk Dorsey, Maryaland 4/15/2011 4 Donation 5 Other (Specify) Signature of Funeral Service Licensee ²² Name and Address of Facility Donaldson Funeral Home, P.A. 313 Talbott Avenue Laurel, 20707 -/M00770 Maryland 23a. Part 1. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Pmysician/ disease or condition Medical resulting in death) Due to (or as a consequence of Examiner Facuanticly list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Due to (or as a consequence of) Exami The law requires that the death certificate be executed attending physician and for use as the burial-tran Due to (or as a consequence of): resulting in death) Last Physician/Medical Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months?

1 Yes 2 No Day Month Year Pregnant at time of death been signed by the should be detached 9 Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Records, 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 s has autopsy performe 1 Tyes 2 🗌 No Yes Division of Vital or Attending Physician: 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 2 3 No မ 1 Inpatient 2 ER/Outpatient 3 DOA funeral din this n 24 hours after death.

Ie Funeral Director: After the bleted filled in by the funeral. Certificate: 27. Manner of Death 28a. Date of injury 28b. Time of 28c. Injury at 28d. Describe how injury occurred (Month, Day, Year) 1. Natural 5 Pending 1 Tes 2 No Investigation 6 Could not be Accident 3 ☐ Suicide 4 ☐ Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number City or Town, State) determined Medical Hospital 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. within 24 hor To the Fune completed fi Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check the 3 _ Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of cartific who controlled cause of death (Item 23a) (Type, Print) ANNAPORI MO 21401 DEFENSE Hay 1. La l'ENTA 441 31. Date filed (Month, Day, Year) 32. Registrar's Signature State

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Dav Month Physician/ 02: 12A M 02 20 11 Medical 4a. Facility Name (if not institution, give street and number 4b. City, Town, or Location of Death 4c. County of Death Examiner TIMORF N/A If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign Age (In vrs. last birthday **Funeral** Min. Davs 1 X M 2 D F Months Hours Mary land 219 22 3306 83 Director Usual Residence of Decedent items 23a or 28a-f shov 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County with the Maryland Examiner must be notified at Director Anne Arundel Baltimore Maryland 1 Yes 2 X No 10g. Citizen of What Country? 10e, Street and Number 10f. Zip Code Funeral 21225 U.S.A. 5602 Sandy Bluff Way permit. Page 1 and 2 should be filed within 72 hours after death v Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or itemmany injury or other trainments. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. 11 Marital Status Armed Forces? Black, White, etc. ģ 1 Never Married 2 Married X Yes 2 No Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify. Specify: If Yes, Give 3 XWidowed 4 Divorced White Completed Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business Industry Elementary/Seconday (0-12) College (1-4 or 5+) Dock Worker Checker 10th Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Catherine Baumgart Frank Markowski 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Baltimore, Maryland 21211 Christine Gazurian / Daughter 608 Craycombe Avenue 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 X Burial 2 Cremation 3 Removal from State 04/06/2011 Baltimore, Maryland 4 Donation 5 Other (Specify) Cross Cemetery 21. Signat of F neral Service Line 22. Name and Address of Facility Gonce Funeral Service, P.A. Tono Ritchie Highway Baltimore, Maryland 21225 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate shock, or heart failure. List only one cause on each line Onset and Death Immediate Cause (Final Pnysician/ disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of) attending physician and for use as the burial-transit the Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or linjury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23d, Date of delivery 23b. Was decedent pregnant ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year Day Other (specify) Pregnant at time of death signed by the a Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 2 No 3 ☐ Probably 4 ☐ Unknown 1 🗌 Yes Completed been 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an cate has l autopsy performed' certificate 1 ☐ Yes 2 ☐ No 25. Was case referred to medica 26. Place of Death (Check only one) B B examiner? Hospital: 1 Tes 2 40 ၉ ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 this 28a. Date of injury (Month, Day, Year) After thi 27. Manner of Beath 28b. Time of 28d. Describe how injury occurred Certificate: 28c. Injury at iniury 5 Pending 1 Natural 1 Yes 2 No 2 Accident
3 Suicide
4 Homicide Investigation within 24 hours after death To the Funeral Director: 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined Medical Ertifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a, Certifiei 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifie 001 APRIL 02, 2011 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 3001S HANOVER STREET, BALTIMORE, MD.

DHMH 17 Rev 7/2009

State Registrar MASRI

31. Date filed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Amend Item 1 State of Maryland Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death John. Joseph McHale Sr. Month Year Physician/ 2011 1052 KM Medical 4a. Facility, Name (if not institution, give street and number 4b. City, Town, or Location of Death 4c. County of Death **Examiner** tarhor 1705 N/A Bultimore Md If Under 1 Year If Under 24 Hrs. Security Numbe Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Months Days Hours 1 🕱 M 2 🗆 F 04/25/1928 82 Treland 213 30 1163 Director Usual Residence of Decedent or 28a-f show notified at 10b. County 10c. City, Town or Location 10d. Inside City Limits 10a, State Director 1 ☐ Yes 2 🕱 No **Baltimore** Maryland Anne Arundel 10g. Citizen of What Country? 10e. Street and Numbe 0f. Zip Code ò "natural", or items 23a o edical Examiner must be by Funeral with 1 U.S.A. 21225 309 Doris Avenue permit. Page 1 and 2 should be filed within 72 hours after death v Department of Heath and Mental Hygiene.
Important: If Item 27 is marked other than "natural", or items any injury or other traumatic event, the Medical Examiner mu 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Never Married 2 Married 1 Yes Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify. Specify: 3 🗆 Widowed 4 🗆 Divorced White Completed Year or Dates 15. Decedent's Education 16a Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Police Officer Baltimore City 11th Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) ပ္ James McHale Norah McHale 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Baltimore, Maryland 21225 309 Doris Avenue Dorothy McHale / Wife 20c. Location - City or Town, State 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 1 Burial 2 Cremation 3 Removal from State Baltimore, Maryland Holy Cross Cemetery 04/11/2011 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Gonce Funeral Service, P.A. 4001 Ritchie Highway Baltimore, Maryland 21225 28a. Part 1. Enter the disease, or shock, or heart failure. List complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate only one cause on each line. Interval Between Immediate Cause (Final Onset and Death Myocarche Physician disease or condition resulting in death) Medical Due to (or as a consequence of): Examine Sequentially list conditions. Examine if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of): Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or iinjury use as the burial-tran **Director:** After this certificate has been signed by the attending physician and in by the funeral director, page 2 should be detached for use as the burial-trar that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: yes, outcome of pregnancy

Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months? Day 4 Pregnant a Month Year Pregnant at time of death g Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e Did tobacco use contribute to the cause of death? Completed by 2 🗹 No 3 Probably 4 Unknown 1 Yes 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 Yes 2 No Be 25. Was case referred to medical 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No မ 1 Yes 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 24 hours after death.

Funeral Director: After this 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending work? 1 🗌 Yes 2 🗌 No 2 Accident
3 Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined within 24 hours aft

To the Funeral Di

completed filled in Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check 3 🗆 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) the 29d. Pate signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number ಲ

State Registrar

31. Date filed (Month, -Day; Year)

DHMH 17 Rev 7/2009

Baltimere, Mary lund

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death Time of Death 1. Decedent's Name (First, Middle, Last) Vaai 5.25 A **Physician** 2011 Mac /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner (51M timae 4 Birthplace (State or Foreign Country) 5. Social Security Number Date of Birth (Month, Day, Year) **Funeral** Months Days 217-12-6008 Director 88 02/19/1923 MD Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Evantinat rust be nutified at once. 10d. Inside City Limits 10c. City, Town or Location 10b. County 1 XYes 2 □ No Director MD BALTIMORE 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code Funeral 1826 RAYNER AVENUE 21217 USA 12. Was Decedent Ever in U.S Armed Forces? 1 ☐ Yes 2 ☐ No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 ☐ Never Married 2 ☐ Married 3altimore, Maryland 21215-0036 If Yes, Give Year or Dates: 1943–46 1 ☐Yes 2 XNo Specify: þ 3 Widowed 4 □ Divorced BLACK Be Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16h Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) BETHLEHEM STEEL FORKLIFT OPERATOR 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ JOHN MACK FLORENCE SMITH 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 6630EBERLE DRIVE APT. 203 BALTIMORE, MD 21215 ROBERT T. WAGONER/NEPHEW 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 □ Cremation 3 □ Removal from State OWINGS MILLS, MARYLAND GARRISON FOREST CEM. 4-18-2011 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee JAMES A. MORTON & SONS F.H., INC. 91 BALTIMORE, MD 1701-31 LAURENS ST. Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complications that crused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical s a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examiner the Hospital or Attending Physician: The law requires that the death certificate be executed resulting in death) Last Due to (or as a consequence of): Box 68760. Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death
4 Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 □ Yes 2 □ No Month Day Vear 5 ☐ Other (specify) P.O. 9 Unknown 9 I Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, Be Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 2 No 1 □ Yes 2 No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident Director: / 6 Could not be determined 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours a 29a. Certifier 💌 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check only

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Registrar DHMH 17 Rev 1/2001

State

29b. Signature and title of certifier

Date filed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

11-02598 Lynda C. Miller Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

_y	ida C. Miller		1- For State Registrar	tate of Maryla		artment o		d Mental I	F	Reg. No. 201	20			
Physician/ Medical Examiner			1. Decedent's Name (First, Midd Lynda C. Mi		2. Date of Dea Month April 5, 2	Day Year	3. Time of Death 0935 hrs							
			4a. Facility Name (if not instituti 3456 Cardenas Aven	-	th	4c. County of D	Death							
	Funeral Director		5. Social Security Number	6. Sex	7. Age (In yrs. I	last birthday)	If Under 1 Year Months Days	+). Birthplace (State or oreign			
	Director		216-48-0451 Usual Residence of Decedent	1 M 2X F	6	62 Yrs		Tiodis ivi		, 1948	Country)Maryland			
	any .		10a. State 10b. County	· · ·	10c. City	, Town or Locat	ion	_			10d. Inside City Limits			
	Maryland 28a-f show d at once.	ē	MD			Balti	more				1 X Yes 2 No			
	e Mary rr 28a-	irec	10e. Street and Number				10f. Zip Code			10g. Citizen of What	Country?			
4	with th IS 23a I	a D	3456 Cardenas		edent Ever in U	.S. 13. Wa	212 s Decedent of Hisp		Specify Yes or No		USA merican Indian, Black,			
)	death or item	Funeral Director	1 Never Married 2 N	1 Yes	2 X No		es, specify Cuban,			White, e				
0	MOFE, MD 21215-0036 Pages I and 2 should be filed within 72 hours after death with the Maryland tent of Health and Mental Hygiene. unt: If item 27 is marked other than "natural", or items 23a nr 28a-f shour other traumatic event, the Medical Examiner must be notified at once.	<u>۾</u>	3 Widowed 4 X Div 15. Decedent's Education (Spe	orced If Yes, Give Year or Dates:		1	Yes 2X No	<u> </u>			white			
-	72 hour	Completed	Elementary/Secondary (0-12)				t's Usual Occupation ost of working life. I			16b. Kind of Busine	ess/Industry			
	21215-0036 within 7 Mental Hygiene. marked other than c event, the Medical	dш	12	4			teacher/			educatio	n/healthcare			
	ID 21215-003 is should be filed within and Mental Hygiene. 7.7 is marked other the matic event, the Media	Be Co	17. Father's Name (First, Middle William Charl				18			Maiden Surname)				
	212 ould be d Ment s mark	To B	19a. Informant's Name/Relations			19b. Mailing	Address (Street	and Number or	Rural Route Nur	e O'Brien mber, City or Town, S	State, Zip Code)			
	and 2 should ealth and N tem 27 is n traumatic		William Kuc	hmas/broth						MD 2123				
	Baltimore, MI permit. Pages 1 and 2 s Department of Health a Important: If item 27 injury or other traum		20a. Method of Disposition 1 Burial 2 Cremation	n 3 Removal fro		Place of Dispos crematory or oth	ition (Name of ceme ner place)	etery,	Date	20c. Location - Cit	y or Town, State			
	it. Pagartment ortant		4 X Donation 5 Other S, 21. Signature Funeral Se in Ronal	pecify:		22. N	ame and Address o	of Facility	1 (#= -	7 7 1				
	Per Den ii	ri i	Ronald	ade, D	irector		ate Anato ltimore,			V. Baltimo	re Street			
	Physician \/Medical		23a. In rt I. Enter the disease, or fail se. List only one cause	complications that ca on each line.	used the death.	. Do not enter th	ne mode of dying, so	uch as cardiac	or respiratory arr	est, shock, or heart	Approximate Interval Between Onset and			
	Examiner		Immediate Cause (Final disease or condition resulting in death) Due to (or as a consequence of): Due to (or as a consequence of):											
		L	Sequentially list conditions,	b										
		Examiner	if any, leading to immediate cause. Enter Underlying Cause (Disease of injury that initiated	Due to (or as a c	consequence of	f):								
	ted J unsit	Exal	events resulting in death) Last	Due to (or as a d	consequence of	f):								
	30, te be executed ysician and burial - transit	edical	X UNPENDED	¬ — —	23a,27,2	28a-f,p	er me,g91	5 6-2-1	1 sm					
	760, icate be physici the buri		IF FEMALE: 23b. Was decedent pregnant in th	23c. If yes, or	utcome of pregr					23d. Date of deli	very			
	Box 6876(death certificate the attending phy ed for use as the t	ician	past 12 months?	4 Pregna	th nt at time of dea	ath -	aldeath 3 _ er (Specify)	_Ectopic pregn	ancy	Month	Day Year			
	Bo.	Physician/M	1 Yes 2 No 9 V Uni											
	ision of Vital Records, P.O. Box 68760, Attending Physician: The law requires that the death certificate be executed reath. veror: After this certificate has been signed by the attending physician and by the funeral director, page 2 should be detached for use as the burial - transi	Š	Part II. Other significant condit	contributing to	death but not re	esuiting in the ui	nderlying cause giv	en in Part I.			e to the cause of death? Probably 4 Unknown			
	of Vital Records, g Physician: The law require the this certificate has been si meral director, page 2 should b	Completed							24a. Was		autopsy findings available			
	Reco The law cate has	E O							autop perfor	med? death	ned? death?			
	Vital Reysician: The his certificate director, page	Be	25. Was case referred to medical examiner?					f Death (Check			7.55			
	n of Vir ling Physic After this funeral dir	욘	1 Yes 2 No 27. Manner of Death	Hospital: 1 In		ER/Outpatient 28b. Time of In				Residence 6 O	ther: Scene			
	conding ath.	ţi	1 Natural 5 Pend	ing (Month, i	Day,Year)	fd 9:29	1 Va	s 2 X No			14.14.4			
,	Division pital or Attendil ours after death. ceral Director: Affilled in by the fu	Certification:	- = -	ligation			, factory, office buil	lding, etc.	28f. Location (S		Rural Route Number, City			
Ì	ospital hours a		4 Homicide deter		Residen						rdenas Ave.			
	Divisior To the Hospital or Attend within 24 hours after death To the Funeral Director: completely filled in by the	Medical	(Check only Certifying Pr	nysician: To the best niner:On the basis of	examination an									
	F	Me	29b. Signature and title of certifie	and manner sta	ted.	1 1	29c. License r	number		29d. Date signed (Month, Day, Year)			
			Colun	M	14	5	O.C.M.	.E.		April 6, 2011				
			 Name and address of person Zabiullah Ali, M.D. 	who completed cause Assistant Medica	•		Street, Baltim	nore, MD 21	201					
	St	ate	31. Date filed (Month, Pay/Yea)	/	istrar's Signatur									

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Certificate of Death . Decedent's Name (First, Middle, Last) 2. Date of Death 3 Time of Death Physician/ APRIL 2011 9:10 P MCCURDY HAZEL Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner HARFORD FOREST HILL HEALTH & REHAB CENTER FOREST HILL If Under 1 Year If Under 24 Hrs. Social Security Number 6. Sex 8. Date of Birth 9. Birthplace (State or Foreign 7. Age (In vrs. last birthday) Funeral Months Days Hours Min Mary land 1 🗆 M 2 🙀 F 4/12/1916 213-09-8225 94 Director Usual Residence of Decedent or 28a-f shov notified at 10a. State 10b. County 10d. Inside City Limits within 72 hours after death with the Maryland 10c. City, Town or Location Director 1 Yes 2 XNo Maryland Baltimore Towson 10e. Street and Number 10g. Citizen of What Country? 10f Zip Code must be r 21204 Funeral 1624 Alston Road U.S.A 12 Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14 Race - American Indian 11 Marital Status Examiner Armed Forces? Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. ō þ 1 Never Married 2 Mamed Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 ☐ No Specify: Specify: White "natural", 3 X Widowed 4 Divorced Completed the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working 16b. Kind of Business Industry permit. Page 1 and 2 should be filed within 72 Department of Health and Mental Hygiene. Important: If item 27 is marked other than 'any injury or other traumatic event, the Me life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Engineering Secretary Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Teresa Kimpel Frederick Guttenson 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1510 Forest View Drive Forest Hill, Maryland 21050 Jeanne Sternal / Niece 20a. Method of Disposition
1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date Hillton Service Corp. 4/13/2011 Towson, Maryland 4 Donation 5 Other (Specify) 22. Name and Address of Facility Ruck Towson Funeral Home, Inc. 1 Towson, Maryland 21204 1050 York Road 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final end of Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examiner Due to (or as a consequence of) Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or injury that initiated events resulting in death) Last and the burial-tran Due to (or as a consequence of) attending physician Physician/Medical Division of Vital Records, P.O. Box 68760 use as IF FFMALE 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 3 Fctopic pregnancy in the past 12 months?

1 Yes 2 No
9 Unknown Day Pregnant at time of death 5 Other (specify) 4 Pregnant 9 Unknown been signed by the s Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 4BP 1 Yes 2 No 3 Probably 4 Nnknown 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? Yes 2 No has page 2 After this certificate 25. Was case referred to medical funeral director, 26. Place of Death (Check only one) Be examiner? 1 Yes 2 No Hospital ျှ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) Manner of Death 28b. Time of 28c. Injury at work? 1 ☐ Yes 2 ☐ No Certificate: 28d. Describe how injury occurred injury 5 \square Pending Natural Accident Investigation 24 hours after deal Funeral Director; Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, filled in by 4 Homicide determined City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier сопріете Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 3 □ within 2 To the F only one 29b. Signature and title of certifie 29c. License numbe 29d. Date signed (Month, Day, Year) 03 2299 Apr. 1 12 201 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DHMH 17 Rev 7/2009

State

Registrar

DAVID DUNN

31. Date filed (Month, Day, Year)

APR 1 4 2011

arkel

21014

BEL AIR, MD.

615 W. MACPHAIL ROAD

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene, For State Registrar Certificate of Death Reg. No Month 1. Decedent's Name (First, Middle, Last) 3 Time of Death MOORE 3CA Physician/ WNA Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Prince George's Mitchellville 1712 Tilia Way . Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign 6. Sex 7. Age (In yrs. last birthday) **Funeral** Feb. Z, 1 M 2 K F Days Min Months Hours Yegr920 Virginia 91 579-28-2809 Vrs Director Usual Residence of Decedent 28a-f shov 10d. Inside City Limits 10b. County at 10a. State 10c. City, Town or Location Director notified 1 ☐ Yes 2 🕅 No Virginia Fauguier The Plains ь 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? e 23a Funeral 20198 U.S.A. 7227 John Marshall Highway Examiner must "natural", or items 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian Armed Forces?

1 Yes 2 X No
If Yes, Give Black, White, etc. by 1 X Never Married 2 Married Baltimore, Maryland 21215-0036 within 72 hours after 1 ☐ Yes 2 X No Specify. Specify: Black 3 Widowed 4 Divorced Completed Year or Dates Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) permit. Page 1 and 2 should be filed within 7. Department of Health and Mental Hygiene. Important: If item 27 is marked other than any injury or other traumation. Elementary/Seconday (0-12) College (1-4 or 5+) Laundry Supervisor 6 Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည William A. Bland, Sr. Ruth Beatrice Grant 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1712 Tilia Way., Mitchellville, MD 20721 Audrey V. Haley (Daughter) 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 A Burian Cremation 3 Removal from State 4/18/2011 The Plains, VA Grant Family Cemetery 4 Donation 5 Other (Specify) 21. Signal re of Funeral Service Licen 22. Name and Address of Facility Joynes Funeral P.O. Box 3633, Home, Inc. Warrenton, VA 20188 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest Approximate shock, or heart failure. List only one cause on each line Interval Between Onset and Death Immediate Cause (Final Ph_sician/ disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to in insolate cause. Enter Underlying Cause (Disease or iinjury Examine Due to (or as a consequence or) ig physician and as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Hospital or Attending Physician: The law requires that the death certificate be Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death nse 23d Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months?

1 Yes 2 No Year ō Month Day Pregnant at time of death detached Unknown 9 Unknown signed by t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 2X No 3 Probably 4 Unknown 1 🗌 Yes been . Were autopsy findings available prior to completion of cause of 24a. Was an autopsy certificate has page death? 1 Yes Yes **Division of Vital** 25. Was case referred to medical funeral director. 26. Place of Death (Check only one) Be examiner? Hospital Other: 2 No 1 Tes မ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence this 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred Natural work? injury 5 Pendina s after death.

Il Director: Aft
ed in by the fur M Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) within 24 hours at To the Funeral D completed filled in Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practioner. To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title 29c. License number 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DHMH 17 Rev 7/2009

State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 1- State of Maryland / Department of Health and Mental Hygiene Registrar 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Month Physician/ Year 2011 Carl Joseph Maus, Jr. 1415 PM Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner TIME Security Numb If Under 24 Hrs. 7. Age (In vrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign Date of Day, Year)
(Month, Day, Year)

16, 1934 **Funeral** Min. 1 🛛 M 2 🗆 F Months Davs Hours Maryland 219-32-7326 Director Feb Usual Residence of Decedent 28a-f show 10b. County 10d. Inside City Limits ä 10a. State 10c. City, Town or Location Director White Marsh notified Baltimore MD 1 Yes 2 XNo 10f. Zip Code 10g. Citizen of What Country? 10e, Street and Number ò er than "natural", or items 23a or the Medical Examiner must be a Funeral 21162 United States 5506 Madge Court death v Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, 11. Marital Status Armed Forces?

1 Yes 2 X No Black, White, etc. 1 Never Married 2 Married þ Maryland 21215-0036 within 72 hours after 1 ☐ Yes 2 No Specify: If Yes, Give Year or Dates Specify: White Completed 3 Widowed 4 X Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b, Kind of Business Industry Moisture Proof & and Mental Hygiene. is marked other than Elementary/Seconday (0-12) College (1-4 or 5+) Estimator Masonry Inc. 12 Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) ည Sara Eliza Stancill Carl Joseph Maus, Sr. permit. Page 1 and 2 should be Department of Health and Meni Important: If item 27 is marke any injury or other traumatic once. traumatic 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mary Marston/ Partner 5506 Madge Court, White Marsh, MD 21162 Baltimore, 20b. Place of Disposition (Name of 20c. Location - City or Town, State 20a. Method of Disposition April 9, 2011 cemetery, crematory or other place)
Evans Funeral Chapel 1 ☐ Burial 2X Cremation 3 ☐ Removal from State Forest Hill, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility
Evans Funeral Chapel & Cremation Services
8800 Harford Rd. Parkville, MD 21234 21. Signature of Funeral Service Licenses Evans Funeral Chapel & O 8800 Harford Rd. Parkvill

3a/Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death mediate Cause (Final Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner sequestially list condition, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury that initiated events resulting in death) Last Examine Due to (or as a consequence of): the burial-transi EXAMINER Due to (or as a consequence of): ending physician use as the burial APPROVED BY Physician/Medical or Attending Physician: The law requires that the death certificate be CERTIFICATIO IF FEMALE 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 3 Ectopic pregnancy
4 Pregnant at time of death 5 Other (specify) 23b. Was decedent pregnant 23d. Date of delivery Box signed by the atten d be detached for u in the past 12 months?
1 ☐ Yes 2 ☐ No Month Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 🕱 No 3 ☐ Probably 4 ☐ Unknown Records, plnous Completed 24b. Were autopsy findings available 24a. Was an page 2 s autopsy performed? 1 Yes 2 No prior to completion of cause of has death?
1 Yes 2 No certificate Division of Vital 25. Was case referred to medical 26. Place of Death (Check only one) director, Be examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 X Yes ၉ 1 Inpatient 2 ER/Outpatient 3 DCA this funeral 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: within 24 hours after death.

To the Funeral Director: After of the funeral pirector of the funeral completed filled in by the funeral completed filled in the funeral completed filled filled in the funeral completed filled fille iniury 1 🖾 Natural 5 \square Pending work? 1 ☐ Yes 2 ☐ No Accident
Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Hospital Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 2 6-2011 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Towson Mn 21204

State Registrar 31. Date filed (Month, Day, Year)

32. Redistrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 1 - State of Maryland / Department of Health and Mental Hygiene Registrar

State of Maryland / Department of Health and Mental Hygiene Certificate of Death

Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ ^{Day} 3 2:00 PM 2011 march tmanda Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death of University Baltimore Maryland Med (en If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) | Aug., 25, 1979 Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign Funeral 1 M 2 AF Towson, Maryland 217-02-0149 31 **Director** Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important if filem 27 is marked other than "natural" any injury or other traumatic event. 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director Parkville Baltimore County Maryland 1 Yes 2 X No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 7710 Park Drive 21234 United States 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12 Was Decedent Ever in U.S. 14 Race - American Indian 11. Marital Status Armed Forces? Black, White, etc. þ 1 Never Married 2 Married White 1 ☐ Yes 2X No Specify: If Yes, Give Year or Dates Completed 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) 12 03 Student Student Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ೭ Cassandra Celeste Dobler Russell Louis Miller 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mr.Russell Louis Miller(Father) 21120-9455 1203 Molesworth Road Parkton, Maryland 20c. Location - City or Town, State (Harford County) 20a. Method of Disposition 20b. Place of Disposition (Name of Date Friday, March 25,2011 Evans Fureral Chapel and Cremation Services, Inc. 1 Burial 2 Cremation 3 Removal from State Forest Hill, Maryland 4 ☐ Donation 5 ☐ Other (Specify) Signature of Funeral Service/Licensed Jeffrey L. Gair, Sr. 22. Name and Address of Facility
Feaceful Alternatives Funeral and Cremation Center, P.A. 1 Lic.#M00677 2325 York Road Timonium, Maryland 23a. Par 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or hear failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician Intracerebra day temorr disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Bacteremi Sequentially list conditions, Examiner If any, leading to immediate cause. Enter Underlying ocoin Cause (Disease or linjury that initiated events the burial-transi and Due to (or as a consequence of) CERTIFICATION APPROVED BY MEDICAL EXAMINER resulting in death) Last Physician/Medical Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months? Month Day Year Pregnant at time of death Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? à Endo carditi Division of Vital Records, 1 Tes 2 No 3 Probably 4 Unknown Hospital or Attending Physician: The law requires Completed page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed Yes 2 1 ☐ Yes 2 ☐ No Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: မ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: 1 Natural work 5 Pending 1 Yes 2 🗌 No Accident Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) completed filled in by 4 Homicide determined 24 hours Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check To the P within 2 To the P Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one 29b. Signature and title of certifie completed cause of death (Item 23a) (Type, Print) 30. Name and addres 22, Suff Greene Street Baltimeres Jol 31. Date filed (Month, Day, Yea Registrar's Signatur State

11-02733

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

2011 12024 State of Maryland / Department of Health and Mental Hygiene Aaron Martinez Certificate of Death 1- For State Reg. No. Registrar 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Physician/ Month Da April 9, 2011 1417 hrs JOSEPH MARTINEZ al Examiner HARON 4c. County of Death 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Baltimore** Johns Hopkins Bayview Medical Center If Under 1 Year If Under 24Hrs. 8. Date of Birth (MM/DD/YYYY) 9. Birthplace (State or 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** Hours Months Days Director Country) mD -OS-ZOII 1 M 2 F Usual Residence of Deceden 10d. Inside City Limits 10c. City, Town or Location 10b. County 1 Yes 2 No BALLIMORE DUNDALK Director 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code Colgare AVENUE 91999 Funeral 14. Race - American Indian, Black, 11 Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Armed Forces 1 Never Married Yes Specify: WhiTe If Yes, Give Year or Dates: Yes 2 No specify: 4 Divorced ě 16a. Decedent's Usual Occupation (Give kind of work done 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Completed during most of working life. DO NOT use retired) Elementary/Secondary (0-12) INFANT Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within Department of Heath and Mental Hygene.
Important: If item 27 is marked other than injury or other traumatic event, the Medica INFANT 18.Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) KRISTINE MARTINEZ MANDLE 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, \$tate, Zip Code) 19a. Informant's Name/Relationship (Type, Print) (mother) ColgATE BACTIMORE, md Ave 51993 KRISTINS 20a. Method of Disposition

1 Burial 2 Cremation 3 Removal from State 20b. Place of Disposition (Name of cemetery, Date crematory or other place) GLON BURNIE, MD Atlantic Chematory 4-13-2011 4 Donation 5 Other Specify: 21. Signature of Funeral Service License 2134 Willow Spring BRADLE ASHIBN F.K. P.A. mo 212 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Approximate Interval Physician Between Onset and failure. List only one cause on each line. /Medical Death a Sudden Unexplained Death in Infancy (SUDI) Immediate Cause (Final disease **Examiner** or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions Due to (or as a consequence of): Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated Due to (or as e consequence of): events resulting in death) Last signed by the attending physician and be detached for use as the burial - tra Physician/Medical AMENDED 23a, 27, 28a-f, per me, g916 6-22-11 sm [™] UNPENDED Division of Vital Records, P.O. Box 68760, 23d. Date of delivery 23c. If yes, outcome of pregnancy IF FEMALE: 23b. Was decedent pregnant in the 1 Live birth 3 Ectopic pregnancy Day Year 2 Fetal death past 12 months? Pregnant at time of death 5 Other (Specify) 1 Yes 2 No 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 Yes 2 No 3 Probably 4 V Unknown Completed certificate has been s ector, page 2 should 24b. Were autopsy findings available 24a. Was an prior to completion of cause of autopsy performed? Yes 2 No 2 No 1 🗸 Yes 26.Place of Death (Check only one) e Hospital or Attending Physician: 24 hours after death. 25. Was case referred to medical å examiner? Hospital: 1 Inpatient 2 🗹 ER/Outpatient 3 🔲 DOA Other Nursing Home 5 Residence 6 Other this 1 Yes 2 No After 1 28c. Injury at Work? 28d. Describe how injury occurred 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 27. Manner of Death Certification: 1 Natural Unknown 1 Yes 2 X No 5 Pending Funeral Director: fd 4-9-11 fd 1:30 pm 2 Accident Investigation 28f. Location (Street and Number or Rural Route Number, City or Jown, State 236 Colgate Ave. Dundalk, Md. 28e. Place of Injury - At home, farm, street, factory, office building, etc 3 Suicide 6 X Could not be (Specify) found at home determined 4 Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) To the l within 2. To the F and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier O.C.M.E. April 10, 2011 30. Name and address of person who completed cause of death (Item 23a) Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201 Patricia Aronica-Pollak MD. 31. Date filed (Month, Day, Year) APR 1 4 2011 32. Registrar's Signature Registrar

DHMH 17 Rev 1/2001

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

		For State	State of Ma	ryland /	•			Mental Hy		2011	12025
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Funeral Director			Sex 7. Age ((In yrs. last bi 63	irthday) . Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Bi (Month, Da Septembe	rth a <i>y, Year)</i> E r 2,		hplace (State or Foreign Intry) LSCONSIN
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land 27275-0036 be filed within 72 hours after death with the Maryland ental Hygiene. rked other than "natural", or items 23a or 28a-f show ite event, the Medical Examiner must be notified at	þ	1 ☐ Never Married 2 💹 Married 3 ☐ Widowed 4 ☐ Divorced	Armed Forces? 1 Yes 2 N If Yes, Give Year or Dates.	lo		Yes, specify Cubar Yes 2 X No		Rican, etc.)		Black, White Specify: W1	e, etc. hite
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mo Page nento int: If		1 Burial 2 X Cremation 3 4 Conation 5 Other (Spec	☐ Removal from State	cemet	West	etory or other place Arundel ematory	e) Apri 20	1 13, 11	Ode	enton, M	faryland
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Ph sician/	5	shock, or heart failure. List only Immediate Cause (Final disease or condition	one ea use on each line.			ng Cance:				is.	Interval Between Onset and Death Months
Medical Examiner		resulting in death)	Due to (or as a	consequence	∍of):						
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DIVISION Of VITAI HECOIDS, F.O. BOX 68 / 60 with the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director. After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit	Physician/M	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ▼ No 9 □ Unknown	23c. If yes, outcome of Live Birth 2 4 Pregnant at 9 Unknown	E Fetal dea		Ectopic pregnanc Other (specify)	у			23d. Date of del Month	ivery Day Year
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51		Danny Lee, M.D.,	·				. Marvla	nd 2111	3		
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11-02645 Kevin McClellan Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.
State of Maryland / Department of Health and Mental Hygiene

(evin McClellan	State of Maryland / Department of Health and Mental Hygierie 1- For State Certificate of Death Reg. No. 20	12026
Physician/	Registrar 2. Date of Death 3. Tim	ne of Death
Medical Examine	Kevin Michael McClellan, Sr. April 7, 2011 03	321 hrs
	4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Anne Arundel Anne Arundel	
	Baitimore washington wedicar Center	(State or
Funeral Director	Months Days Hours Min.	
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Maryli Maryli gi at o	10e. Street and Number 10f. Zip Code 10g. Citizen of What Country?	
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r death with the Maryland or items 23a or 28a-f sh : must be notified at once Funeral Director	11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American in the Specify Cuban, Mexican, Puerto Rican, etc.) 15. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)	
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21215-0036 21215-0036 Juld be filed within 7 Mental Hygiene. marked other than ic event, the Media	R Douglas McClellan Catherine Phillips	
213 could b d Men s marl tic eve	19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip C	
MD and 2 sho alth and m 27 is	Bonnie McClellan/Wife 919 Autumn Valley Lane, Gambrills, MD 210	. State
Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show injury or other traumatic event, the Medical Examiner must be notified at once. To Be Completed by Funeral Director	1 Burial 2 X Cremation 3 Removal from State crematory or other place) April 11,	
Baltimore, permit. Pages 1 ar Department of Hee Important: If ite	4 Donation 5 Other Specify: 2011 Udellett, Hary	
Bal Departing	21. Signature of Function Service Licensee MO1386 Service Licensee 22. Name and Address of Facility Donaldson Funeral Home & Crematory, P. 1411 Annapolis Road, Odenton, MD 21113	Α.
Physician	23a, Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart	proximate Interval
Medical	failure. List only one cause on bach line: Immediate Cause (Final disease a. Atherosclerotic Cardiovascular Disease	Death
Examiner	or condition resulting in death) Due to (or as a consequence of):	
1	Sequentially list conditions, if any, leading to immediate b. Due to (or as a consequence of):	
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Insit	events resulting in death) Last Due to (or as a consequence or).	
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687 certific ading	23b. Was decedent pregnant in the past 12 months?	i oai
b. Box 6876 the death certificate the attending phy ched for use as the Dhysician/M	1 Yes 2 No 9 Unknown 9 Unknown	
Records, P.O. Box 6876 The law requires that the death certificate cate has been signed by the attending phy page 2 should be detached for use as the law physician M.		
Division of Vital Records, P.O. tast after deading Physician: The law requires that the safe dead. **All Directors After this certificate has been signed by led in by the funeral director, page 2 should be detach artification: TO Be Completed by Description.		
tal Records cian: The law requi certificate has been ector, page 2 should	24a. Was an autopsy performed? 1 Yes 2 No 1 Yes 26 Place of Death (Check only one)	etion of cause of
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pital o	4 Homicide determined (Specify)	
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To th within To th comp	(Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cauchy one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cauchy one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Date and Date in the cauchy of the cau	
	O.C.M.E. OCME April 7, 2011	
	30. Name and address of person who completed cause of death (Item 23a)	
	Theodore M. King, Jr., MD. Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201	
Stat Registra		
V(21112) (P		

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State
Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month 6:25 A Physician/ Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Carrol1 Bonds Forest Assisted Living Finksburg If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign 5. Social Security Number 8. Date of Birth 6 Sex 7. Age (In vrs. last birthday) **Funeral** Days Hours Min 10/07/1918 1 X M 2 □ F Kentucky 303 26 0556 92 Director Usual Residence of Decedent show 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location Director ns 23a or 28a-f s must be notified 1 🗌 Yes 2 🗶 No Carrol1 Finksburg Maryland 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 2261 Old Westminster Pike U.S.A. 21048 "natural", or items 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Forces?

1 Yes 2 No
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Betty Zornes 17. Father's Name (First, Middle, Last) Grover C. Masters မ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
310 Leyton Road Reistertown, Maryland 21136 19a. Informant's Name/Relationship (Type, Print) Larry Masters / Son 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other place) 1 Burial 2 ☐ Cremation 3 ☐ Removal from State Glen Burnie, Maryland Glen Haven Mem. Park 04/11/2011 4 Donation 5 Other (Specify) 22. Name and Address of Facility Gonce Funeral Service, P.A. 21. Signature of Funeral Service Licensee 4001 Ritchie Highway Baltimore, Maryland 21225 Namuella 23a. Part 1. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Gollblodder Immediate Cause (Final Carcinoma Ph_sician/ disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner Sequentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of) Examir ng physician and as the burial-tran that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical Box 68760 use 23c. If yes, outcome of pregnancy
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1 ☐ Yes 2 ☐ No jo Month Day Year Pregnant at time of death detached Linknown P.O. þ 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 2 No 3 ☐ Probably 4 ☐ Unknown Division of Vital Records, Completed 24b. Were autopsy findings available prior to completion of cause of 24a. Was an has autopsy death? 1 ☐ Yes 2 ☐ No Hospital or Attending Physician: 26. Place of Death (Check only one) filled in by the funeral director, 25. Was case referred to predica To Be examiner? Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) Assisted Civin 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Mann of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred work? 1 ☐ Yes 2 ☐ No Natural 5 Pending s after death. Accident Investigation 3 Suicide
4 Homicide Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) within 24 hours To the Funeral Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier completed Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29d Date signed (Month, Day, Year) 29b. Signature and title of certifier 7,2011 30. Name and address of pe rson who completed cause of death (Item 23a) (Type, Print) 295 301 State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State
Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ 10 2011 5:30 April Nora W. Moore Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Baltimore Catonsville Charlestown Care Center If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign Social Security Number 7. Age (In yrs. last birthday) **Funeral** 1 🗆 M 2 🔀 F Days Hours 1077071909 New York 087-05-2467 101 **Director** Usual Residence of Decedent 28a-f show 10d. Inside City Limits "natural", or items 23a or 28a-f show 10a. State 10b. County 10c. City, Town or Location within 72 hours after death with the Maryland Director Catonsville 1 Yes 2 K No Baltimore MD 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral United States 715 Maiden Choice Lane 21228 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black, White, etc. þ 1 Never Married 2 Married 1 ☐ Yes 2 🛣 No If Yes, Give Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify: White Specify: Completed Year or Dates and Mental Hygiene.

is marked other than "natur aumatic event, the Medical ! 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Own Home Homemaker Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မှ Bridget Carr Walsh Richard Patrick Walsh permit. Page 1 and 2 should I Department of Health and Me Important: If item 27 is mark 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 229 Prospect Bay Drive West, Grasonville, MD 21638 Richard W. Moore (Son) 20b. Place of Disposition (Name of 20a. Method of Disposition 20c. Location - City or Town, State cemetery, crematory or other place) Burial 2 Cremation 3 Removal from State ō Calvary Cemetery 04/15/2011 Woodside, New York Qonation 5 Other (Specify) 22. Name and Address of Facility Signature of Funeral Service Licenses Hubbard Funeral Home, Inc. any 4107 Wilkens Avenue. Baltimore, Maryland Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest Approximate interval Between shock, or heart failure. List only one cause on each line Onset and Death Immediate Cause (Final disease or condition resulting in death) Cardiovascular Physician/ Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of): attending physician and for use as the burial-transit Cause (Disease or iinjury that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical death certificate be Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death
9 Unknown 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy 5 Other (specify) ____ in the past 12 months?

1 Yes 2 No Month Day Year 1 Yes 2 signed by the a P.O. 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ò enfausion 2 No 3 Probably 4 Unknown Records, Completed should 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an page 2 s autopsy performed Yes 25. Was case referred to medical Division of Vital Hospital or Attending Physician: 26. Place of Death (Pheck only one) Be examiner? Other: 1 Inpatient 2 ER/Outpatient 3 DOA မှ Nursing Home 5 Residence 6 Other (Specify) this within 24 hours after death.

To the Funeral Director: After this completed filled in by the funeral or 28a. Date of injury (Month, Day, Year) 27. Manne of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 Natural work? 1 ☐ Yes 2 ☐ No 5 Pending Accident
Suicide Investigation Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 - Homicide determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifier (Check 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. within 2 only one) 29b. Signature and title of certifie 29d. Date signed (Month, Day, Year) 10 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Maidan Choice Cn Catonsville 2/228 Michael 31. Date filed (Month, Day, Year) State

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Day CERMINE · NEUMEISTER 1025 AM 201 Medical Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner GLEN BURME ANNE AMUNDEL 12 5. Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Days 1 M 2 X F Hours (Month, Day, Year) 08/07/1937 213 36 3743 73 Maryland Director Usual Residence of Decedent 28a-f show 10h Counts at 10a. State 10c. City, Town or Location 10d. Inside City Limits Director Examiner must be notified Anne Arundel Linthicum Marvland 1 Tyes 2 X No 10e. Street and Number 10f. Zip Code 5 10g. Citizen of What Country? items 23a Funeral 216 Coronet Drive 21090 U.S.A. 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc 2 1 Never Married 2 X Married "natural", or Maryland 21215-0036 within 72 hours after 1 Yes 2 X No Specify: Specify: Completed 3 Widowed 4 Divorced White Year or Dates the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) permit. Page 1 and 2 should be filled within 7 Department of Health and Mental Hygiene. Important If frem 27 is marked other than any Injury or other transmits. Elementary/Seconday (0-12) 12th College (1-4 or 5+) Self Employed Transcriptions Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname, John F. Hentz Helen Marie Schmidt 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) George J. Neumeister / Husband 216 Coronet Drive Linthicum, Marvland 21090 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 🔀 Burial 2 🗌 Cremation 3 🔲 Removal from State Cedar Hill Cemetery 04/13/2011 Baltimore, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Signature of Funeral Service Licensee Gonce Funeral Service, P.A. 4001 Ritchie Highway Baltimore, Maryland 21225 ramenous 23er. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart fairne. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death METASTANIC Ph sician/ ENST CAMCEN disease or condition MUSS Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, Examine Due to (or as a consequence of) if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Due to (or as a consequence of) resulting in death) Last burialattending physician for use as the buria Physician/Medical that the death certificate be Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery Ectopic pregnancy in the past 12 months?
1 Yes 2 No
9 Unknown Month Day Year Pregnant at time of death 5 Other (specify) the P.O. ò signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Division of Vital Records, or Attending Physician: The law requires Completed 1 Tyes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performe 1 ☐ Yes 2 ☐ No 25. Was case referred to medical Be 26. Place of Death (Check only one) 1 Yes ပ္ Other: i Inpatient 2 I ER/Outpatient 3 I DOA 4 Nursing Home 5 Residence 6 Other (Specify) funeral 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending s after death. 1 Yes 2 No Investigation 6 Could not be the Accident Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 Homicide determined e Funeral E Hospital Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner stated. ertifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a, Certifier within 24 hor To the Fune completed fi the Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifie 29c. License number who completed cause of death (Item 23a) (Type, Print) MD, 4600 RITUME HIGHWAY MD State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 1 - State of Maryland / Department of Health and Mental Hygiene Registrar

Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month 2 Year Physician/ 2:35PM Eileen Minnie O'Mahonv 01 Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Union Memorial Baltimore 5. Social Security Number 7. Age (In vrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Country) England 1 □ M 2 Days Hours Min. Oct. 31 Yrs 89 Director 078-24-2877 Usual Residence of Decedent or 28a-f show 10a. State 10b. County 10d. Inside City Limits of Health and Mental Hygiene. "Item 27 is marked other than "natural", or items 23a or 28a-f sho other traumatic event, the Medical Examiner must be notified at 10c. City, Town or Location within 72 hours after death with the Maryland Director 1 √ Yes 2 □ No MD Baltimore 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral USA 21209 5954 Green Meadow Parkway Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian Armed Forces?
1 ☐ Yes 2 🗓 No Black, White, etc. Completed by 1 X Never Married 2 Married Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 X No Specify: Specify: 3 Widowed 4 Divorced white 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Legal Secretary Be permit. Page 1 and 2 should be filed v Department of Health and Mental Hyg Important: If item 27 is marked othn any injury or other traumatic event, 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည John Evelyn O'Mahony Minnie Isabel Jackson 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 4003 Perry Hall Road; Perry Hall, MD 21128 Tracey Flockencier / friend Baltimore, 20c. Location - City or Town, State 20a. Method of Disposition 20b. Place of Disposition (Name of 1 Burial 2 Cremation 3 Removal from State cemetery, crematory or other place) Towson, MD Hilltop Service Corp. 2/7/2011 4 ☐ Donation 5 ☐ Other (Specify) 1050 York Road 22. Name and Address of Facility MD 21204 Towson, Ruck Towson Funeral Home, Inc. cations that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, e cause on each line. 23a. Part 1. Enter the disease, or comp shock, or heart failure. List only of Immediate Cause (Final Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition Medical resulting in death) ullation on Coumadia Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Physician/Medical Examiner Due to (or as a consequence of) cate has been signed by the attending physician and page 2 should be detached for use as the burial-transit Cause (Disease or iinjury that initiated events resulting in death) Last PROVED BY MEDICAL EX Due to (or as a consequence of) Hospital or Attending Physician: The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No Month Day 5 Other (specify) Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 🗌 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy performed? Yes 2 No this certificate has death?
1 Yes 2 No 25. Was case referred to medical completed filled in by the funeral director, Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital Certificate: To 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at work? 1 ☐ Yes 2 ☐ No 28d. Describe how injury occurred within 24 hours af er death.

To the Funeral Director: After 5 \square Pending injury 1 Natural Investigation Accident Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 3 🗆 only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year)

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State Registrar Baltimore MD 212

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Varkway

Registrar's Signature

E. Universit

Year). 0 5

200

31. Date filed (Month,

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death 1-1 Physician/ 000 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Anne Arundel 25 Steele Avenue Annapolis Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign 6. Sex Funeral Age (In yrs. last birthday) 1 M 2 D F Months Days Hours Min. (Month, Day, Year) 09/09/1927 North Carolina 238-34-9510 83 **Director** Usual Residence of Decedent 28a-f show permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f shown any injury or other traumatic event, the Medical Examiner must be notified at once. 10b. County 10d. Inside City Limits 10a. State 10c. City, Town or Location Director 1 Yes 2 X No MD Anne Arundel Annapolis 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21401 25 Steele Avenue United States 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status 14. Race - American Indian, Black, White, etc. Completed by 1 Never Married 2 Married 1 X Yes If Yes, Give 2 🗌 No Baltimore, Maryland 21215-0036 Specify: White 1 ☐ Yes 2 X No Specify: 3 Widowed 4 Divorced Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done of life. DO NOT use retired) during most of working Elementary/Seconday (0-12) College (1-4 or 5+) Self Artist Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Blanche Edna Lewis Rhonda Burell Phillips 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 25 Steele Ave., Annapolis, MD Dana Cleland Daughter 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1
Burial 2
Cremation 3
Removal from State 4 Donation 5 Other (Specify) 4/10/2011 Alexandria, VA Metropolitan Crematory 22. Name and Address of Facility Mark D. Heintzelman Funeral & Cremation 21. Signature of Funeral Service Pennsylvania Ave., Centre Hall, PA 16828 0 1 M01284 226 S. 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final OBST RONIC Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine T the Hospital or Attending Physician: The law requires that the death certificate be executed hin 24 hours after death.

the Funeral Director: After this certificate has been signed by the attending physician and Cause (Disease or iinjury that initiated events Due to (or as a consequence of) resulting in death) Last burialattending physician for use as the buria Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregna 5 ☐ Other (specify) Ectopic pregnancy in the past 12 months? Month Day Year Pregnant at time of death signed by the a d be detached f Yes 2 No 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I Be Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown certificate has been si rector, page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed Yes 2 25. Was case referred to medical 26. Place of Death (Check only one) Hospital Other: 2 140 1 Yes မ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Mann of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred injury work? Natural 5 Pending 2 🗌 No 2 Accident
3 Suicide
4 Homicide Investi**g**ation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, completed filled in by determined City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifler Modical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one) 29b. Signature and title of certifie 29d. Date signed (Month, Day, Year) 100 201 who completed cause of death (Item 23a) (Type, Print) 30 Name and address of perso FFENSE HWY, MUDAPOLIS, MD 21401 -1007-4(DR Date filed (Month, Day, Year) 32. Registrar's Signature State

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Edgar Perrv 2011 6:20P. Apri] Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death 4423 Klee Ct. Svkesville Carrol Social Security Number If Under If Under 24 Hrs. 8. Date of Birth Funeral 7. Age (In vrs. last birthday Birthplace (State or Foreign Country) 1 ★ M 2 □ F Months Hours 371671920 Director 213-14-4667 91 Usual Residence of Decedent 28a-f shov 10c. City, Town or Location ms 23a or 28a-f sho must be notified at 10d. Inside City Limits Director 1 ☐ Yes 2 K No Carroll Sykesville 10e. Street and Number 10g. Citizen of What Country? Funeral 4423 Klee Ct. 21784 USA 12. Was Decedent Ever in U.S. Armed Forces? 1XXYes 2 ☐ No 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, or than "natural", or ite the Medical Examiner Black, White, etc. ģ 1 Never Married 2 Married Maryland 21215-0036 If Yes, Give Year or Dates. 1942–46 1 Yes 2XXNo Specify: Specify: White Completed 3 K Widowed 4 Divorced 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) 12 BGE Customer Service Rep. Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Lillian Evans Frank Eugene Perry should to and Me Lepartment of Health and Important: If Item 27 is many injury or other 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 4423 Klee Ct., Sykesville, MD 21784 Ruth Darby/Sister Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 Burial 2 X Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) S. Carroll Crematory 4/14/2011 Winfield, MD 21. Signature of Funeral Service Licenses ²² Name and Address of Facility Funeral Home & Crematory, 1212 W. Old Liberty Rd., Winfield. t. Enter the disease, or complications that chused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, k, or heart failure. List only one cause on e.ch line. Approximate Interval Between Im ne late Cause (Final ENDSTAGE PENAL DISEASE Onset and Death Physician/ disease or condition resulting in death) Lyen Medical Due to (or as a consequence of): Examiner Alhero sclenotic chroiounswan disease if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events resulting in death) Last Examine that the death certificate be executed Due to (or as a consequence of): nding physician ause as the burial-Physician/Medical Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No
9 Unknown Pregnant at time of death 5 Other (specify) P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Severe peripheral Arterial Copose Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown CHRONICOD shockive primonaux duscose 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 No 1 ☐ Yes 2 ☐ No 25. Was case referred to medical examiner? Division of Vital Hospital or Attending Physician: completed filled in by the funeral director, Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No. မ 1 Tyes 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death Certificate: 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred work?
1 \(\sum \) Yes 2 \(\sum \) No 1 Matural injury 5 Pending s after death. 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier 14 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: Dn the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 1)3166U 4/14/2011 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) MOMAS 2 GI STANGER AVENUE WESTA NATER MARGINE CAL Ke I'M mo 2. Registrar's Sign State

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend item 20a per fh g914 4-14-11 vt. State of Maryland / Department of Health and Mental Hygiene. 1 - State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2 Date of Death Physician/ 12^{Day} April Kenneth Pirie 2011 Medical **Examiner** 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death County of Death BALTIMORE chooner HASE If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign **Funeral** Sex 1 M 2 D F 7. Age (In vrs. last birthday) 8. Date of Birth Months Days Hours Min MARY LAND 88 Director Usual Residence of Decedent or 28a-f show 10b. County death with the Maryland Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 ☐ No $\omega_{\mathcal{D}}$ Bourinoes CHASE 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? items 23a Funeral Schooner 21220 Lane 12. Was Decedent Ever in U.S. Armed Forces?

1 X Yes 2 No If Yes, Give Year or Dates. WW II Marital Status 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 1 Never Married 2 Married Black White etc. 5 þ permit. Page 1 and 2 should be filed within 72 hours after Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Specify: White "natural" Completed 3 Divorced 4 Divorced the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Department of Health and Mental Hygiene. Important: If item 27 is marked other than ' any injury or other traumatic event, the Me Elementary/Seconday (0-12) College (1-4 or 5+) MFG Roller reel METAL Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) MARGARET PIP 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 21073 402 10101 MANIMANI 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place 1 Burial 2 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) SARDENSOF FAITH BAITIMORP mp -2011 . Signature of Funeral Service License 2134 Willow Spring RJ BAUTIMEN MD 2122 MD 21222 Autinung 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line andiam. Immediate Cause (Final Onset and Death nomi (Physician/ disease or condition resulting in death) UM Medical Examiner ton Esquentiary list conditions, if any, leading to immediate cause. Enter Underlying Examine Cause (Disease or iinjury that initiated events resulting in death) Last attending physician and for use as the burial-tran Due to (or as a consequence of): Physician/Medical that the death certificate be P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery Live Birth 2 Live Fetal Co.

Pregnant at time of death 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months? Day Yes 2 No 9 Unknown g Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Division of Vital Records, Be Completed 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed After this certificate 1 Yes 2 No Yes 2 1 To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifical completed filled in by the funeral director, I 25. Was case referred to medical 26. Place of Death (Check only one) Hospital 1 Yes 2 No Other: Certificate: To 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 27. Manner of Death Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural injury 5 Pending 2 Accident
3 Suicide
4 Homicide 1 Yes 2 No Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 🛂 🗲 rtifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one 29c. License number 0 7 5 7 5 29b. Signature and title of certifier M.D. 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

MALIKA WASEEM 709 EASTERN BLUP, D. U. 31. Date filed (Month, Day, Year) State Registrar

Hospital or Attending Physician: The law requires that the death certificate be executed Box 68760, P.O. Division of Vital Records,

Certification: To

Medical

n 24 hours after death.

le Funeral Director: Aft
bletely filled in by the fur

Registrar

and manner stated. 29b. Signature and title of certifier

29c. License number

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

1 ☐ Yes 2 ☐ No

29d. Date signed (Month, Day, Year)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Research 2401

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

BLVD Sute 330 Rockwill mo

mendhiratta

32. Registrar's Signature

6 Could not be determined

3 Suicide

29a, Certifier (Check only one)

4 Homicide

31. Date filed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 4 PV V Physician/ 7:15 OMDSON 10m Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** och Raven Community Living Baltimore If Under 1 Year If Under 24 Hrs. 8. Date of Birth Months Days Hours Min. (Month, Day, Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 218-20-2635 1**X** MM 2 □ F 84 **Director** 06/21/1926 MD Usual Residence of Decedent or than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at 10a. State 10c. City, Town or Location 10d. Inside City Limits Director Salisbury Wicomico 1 ☐ Yes 2 🕅 No 10g. Citizen of What Country? USA 10e. Street and Number 10f. Zip Code 21801 Funeral 121 Eastern Avenue within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces? Navy Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. permit. Page 1 and 2 should be filed within 72 hours after to Department of Health and Mental Hyglene. Important: If item 27 is marked other than "natural", or any injury or other traumatic event. The Maries or þ 1 Never Married 2 Married Specify: White Baltimore, Maryland 21215-0036 1 Yes 2 XNo Specify. Completed 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15 Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Self Employed Sales Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) ည unkn. unkn 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
PO Box 69, 6588 Hall Farm Lane, Dublin, VA 19a. Informant's Name/Relationship (Type, Print) William H. Parker / Son 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Date 1 Burial 2 X Cremation 3 Removal from State Final Journey Crem . : 3/15/2011 Woodbine, MD 4 Donation 5 Other (Specify) 21. Signature of Funeral Service Ligensee Dorota Marshall 22. Name and Address of Facility Maryland Cremation Services PO Box 1413, Baltimore, MD 10 21203 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death ancer Immediate Cause (Final una Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of): Examin attending physician and for use as the burial-transit Cause (Disease or iinjury that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical The law requires that the death certificate be Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No Month 5 Other (specify) Pregnant at time of death been signed by the a should be detached t 9 Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? δ 1 Yes 2 No 3 Probably 4 Unknown Records, Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an this certificate has rail director, page 2 s autopsy 2 1 No 1 Yes To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certific completed filled in by the funeral director, **Division of Vital** 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No ပ္ 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at work?
1 Yes Certificate: 28d. Describe how injury occurred injury Natural 5 Pending 2 No ☐ Accident ☐ Suicide Investigation Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier (Check 29b. Signature and title of certifier 2+11 3900 Loch Raven Battimore, Ma Boulgrand 30. Name and address of person who completed cause of death (tem 23a) (Type, Print) Maryland 32. Registrar's Signature 31. Date filed (Month, Day, Year) State 4 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death April 8 Physician/ Paul Mary 6:15 p ^M Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death PG Cheverly PG Community Hospital Birthplace (State or Foreign Country) . Social Security Number 6. Sex 7. Age (In vrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, **Funeral** Days 1 M 2 X F 377-32-7373 78 Yrs. **Director** chigan Usual Residence of Decedent 28a-f shov 10a. State 10b. County 10c. City, Town or Location aţ 10d. Inside City Limits filed within 72 hours after death with the Maryland Director notified MD PG Upper Marlboro Yes 2 ☐ No 10e. Street and Number 10g. Citizen of What Country? 6 10f. Zip Code Examiner must be 23a Funeral USA 11311 Sherrington Ct. 20774 items 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc 6 δ 1 Never Married 2 Married 1 ☐ Yes 2 💢 No If Yes, Give Year or Dates. Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify. Specify: Black "natural" 3 Widowed 4 X Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working Medical Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) and Mental Hygiene. is marked other than life. DO NOT use retired) College (1-4 or 5+) 5+ Elementary/Seconday (0-12) Private Nurse Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) permit. Page 1 and 2 should be file Department of Health and Mental I Important: If item 27 is marked o any injury or other traumatic eve ည Hubbard Alyse Henry Spence 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code, 217 Sparrow Ln. Bolingbrook, Illinois 60490 Debra Moorman/Daughter Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 104-11-11 Brentwood, MD 4 ☐ Donation 5 ☐ Other (Specify) Lincoln Cemetery 21. Ignature of Pineral Service Licensee 22. Name and Address of Faciliting Ronald Taylor II FH 10583 Middleport Ln. White Plains, MD 20695 the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, 23a. Part 1. Enter the disease, or complications that caus shock, or heart failure. List only one cause on each l terval Between Onset and Death Immediate Cause (Final Physician/ Fatal Cardiac Arrhythmia disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Respiratory Failure Sequentially list conditions, if any leading to immediate cause. Enter Underlying Examine sician and burial-transit or Attending Physician: The law requires that the death certificate be executed Cause (Disease or iinjury that initiated events Chronic Repiratory Failure Due to (or as a consequence of) resulting in death) Last attending physician for use as the buria Physician/Medical Chronic Inflammatory Demyelinating Polyneuritis Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death
4 Pregnant at time of death
9 Unknown 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months? Month Day Year been signed by the a should be detached f Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of 24a. Was an prior to completion death? page 2 s autopsy performed certificate 1 Yes 2 No Yes 2 1 25. Was case referred to medical director, Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 2 No 1 Yes မ 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA this funeral 28a. Date of injury (Month, Day, Year) Manner of Death 28b. Time of 28c. Injury at Certificate: After 1 Natural 5 Pending work s after death. 1 Yes 2 No Accident Investigation completed filled in by the Suicide Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined within 24 hours a To the Funeral D Hospital Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner. On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check only one) 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 04-13-2011 D70501 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

State Registrar Anteneh Zeriebe

31. Date filed (Month, Day, Year)

APR 1 4 2011

32. Registrar's Sig

3001 Hospital Dr. Cheverly, MD 20785

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death Month Year Physician 40A 2011 /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) **Examiner Baltimore City** The Johns Hopkins Hospital 8. Date of Birth (Month, Day, Year) If Under 1 Year | If Under 24 Hrs.

Months Days Hours Min. Birthplace (State or Foreign Country) Age (In vrs. last birthday) Social Security Number Funeral 70 April 1941 Rhode 036-26-9868 Director Usual Residence of Decedent 10d. Inside City Limits death with the Maryland 10c. City. Town or Location 10a. State 10b. County show must be notified at 1 X Yes 2 □ No Director PA Franklin Fannettsburg 28a-f 10g. Citizen of What Country? 10f. Zip-Code 10e. Street and Number 5 17221 U.S.A. 23a 17931 Fannettsburg Road East Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 X No 11. Marital Status "natural", or iten Pages 1 and 2 should be filed within 72 hours after 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🛣 No If Yes, Give Specify: þ White 3 ☐ Widowed 4 ☐ Divorced Year or Dates: Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Decedent's Education the Medical (Specify only highest grade completed) al Hygiene. Elementary/Secondary (0-12) College (1-4 or 5+) Construction Supervisor 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be th and Mental H 7 is marked ot traumatic even Mary King James Reilly ၉ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) of Health a 17931 Fannettsburg Rd. East, Fannettsburg, PA 17221 Shirley Reilly (Wife) other t 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 20a. Method of Disposition 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State <u>-</u> ১ Department or Important: If any injury or once. Kelso-Cornelius FH 4-12-11 Chambersburg, PA 4 Donation 5 Other (Specify 22. Name and Address of Facility Kelso-Cornelius Funeral Homes, Inc. 322 North Second St., McConnellsburg, PA 17233 21. Signe ture of Funeral Service Ucense pen 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** Intra abdomna disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner 11 hosis Sequentially list conditions, if any, leauning to immediate cause. Enter Underlying Cause (Disease or injury Examiner Directo for as a consecuence of Hospital or Attending Physician: The law requires that the death certificate be executed physician and as the burial-tran that initiated events Due to (or as a consequence of): resulting in death) Last Division of Vital Records, P.O. Box 68760. Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day Year in the past 12 months?
1 ☐ Yes 2 ☐ No 4 Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown signed by 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I þ 2 No 3 Probably 4 Unknown 1 ☐ Yes Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performe Yes 2 ้ไปก 1 TYes 2 No Yes 26. Place of Death (Check only one) 25. Was case referred to medical Be examiner? Other: 4 \(\subseteq \text{Nursing Home} \) 5 \(\subseteq \text{Residence} \) 6 \(\subseteq \text{Other} \(\text{(Specify)} \) 2 No Inpatient 2 ER/Outpatient 3 DOA 1 🗌 Yes မ this 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 5 Pending investigation Iniury Natural 1 🗌 Yes 2 🗌 No 2 Accident I Director: Af 6 Could not be determined 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 4 - Homicide City or Town, State) 24 hours 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier (check only Medical one) and manner stated. within 2 To the I 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certific Res-00

DHMH 17 Rev 1/2001

State

Registrar

Margaret

31, Date filed (Month, Day, Year)

APR 1 4 2011

600 North Wolfe St, Baltimore, MD, 21287

person who completed cause of death (Item 23a) (Type, Print)

Hayes

H.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Certificate of Death Registrar 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month Physician/ 7 2011 APR 3:30 A M ROBBIE DAVIS ROBERTS Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (if not institution, give street and number) **Examiner** MONTGOMERY BETHESDA NATIONAL NAVAL MEDICAL CENTER If Under 24 Hrs. 9. Birthplace (State or Foreign If Under 1 Year 8. Date of Birth Social Security Number . Age (In yrs. last birthday **Funeral** 1 □ M 2 🏝 F Days Hours 12/23/1931 Country) Arkansas 79 Yrs Director 251-52-7940 Usual Residence of Decedent er than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at 10d. Inside City Limits 10b. County 10c. City, Town or Location within 72 hours after death with the Maryland Director 1 ☐ Yes 2 X No Fairfax Alexandria 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number Funeral 9108 Peartree Landing 22309 Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian 12. Was Decedent Ever in U.S. 11. Marital Status Armed Forces?
1 ☐ Yes 2 ☑ No
If Yes, Give Black. White, etc. 1 Never Married 2 Married δ Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify Specify: White 3 Divorced 4 Divorced Completed Year or Dates 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry Elementary/Seconday (0-12) College (1-4 or 5+) Self Homema<u>ker</u> event, Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) i. Page 1 and 2 should be filec tment of Health and Mental Η tant: If item 27 is marked ot jury or other traumatic even မှ James Harold Davis Loye Virginia Barrett 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 9108 Peartree Landing, Alexandria, VA 22308 Wilson J. Roberts Spouse 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Date 1 🗌 Burial 2 ី Cremation 3 🗌 Removal from State permit. Page Department of Important: If any injury or Metropolitan Crematory 4/08/2011 Alexandria, VA 4 ☐ Conation 5 ☐ Other (Specify) 22. Name and Address of Facility Mayer Funeral Home Signature of Funeral Se ce Lichnsee M01284 SC P.O. Box 2838, Georgetown, 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examine Due to (or as a consequence of): or Attending Physician: The law requires that the death certificate be executed cate has been signed by the attending physician and page 2 should be detached for use as the build be detached for use that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant Ectopic pregnancy in the past 12 months?

1 Yes 2 X No Month Year Day Pregnant at time of death Other (specify) 1 ☐ Yes ∠ , 9 ☐ Unknown g Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 2 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy certificate has performed? 2 🗌 No ☐ Yes 2 ☑ No 1 🗌 Yes director. 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Hospital: 1 K Inpatient 2 ER/Outpatient 3 DOA 1 🗌 Yes 2 😾 No 4 Nursing Home 5 Residence 6 Other (Specify) Certificate: To 24 hours after death. Funeral Director: After this 28a. Date of injury (Month, Day, Year) funeral 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred work?
1 Yes 2 No injury 5 Pending Natural Investigation filled in by the Accident 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) Suicide 6 Could not be 4 Homicide determined To the Hospital Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier within 24 hor To the Fune completed fi Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check 3 □ 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifie MD April 8,2011 01055104A (IN) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) NATIONAL NAVAL MEDICAL CENTER

State Registrar MICHAEL BAYDARIAN

4 2011

31. Date filed (Month, Day, Year)

DHMH 17 Rev 7/2009

BETHESDA MD 20889-5600

LCDR MC USN

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene, For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 11 2 30 FM 2011 Roberta G. Roberts Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Union Memorial Hospital Baltimore 9. Birthplace (State or Foreign Social Security Number If Under 1 Year If Under 24 Hrs. 8, Date of Birth 6 Sex **Funeral** 7. Age (In vrs. last birthday) (Month, Day, Yea an 28, 1 Maryland Hours Min 1 □ M 2 🂢 F 93 Jan Director 213-36-1159 Usual Residence of Decedent item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at 10a. State 10h County 10c. City, Town or Location 10d, Inside City Limits Director 1 X Yes 2 □ No MD Baltimore 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number Funeral USA 200 Cross Keys Road #30 21210 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. 1 Never Married 2 Married Completed by Baltimore, Maryland 21215-0036 black. 1 ☐ Yes 2 🕅 No Specify: 3 X Widowed 4 Divorced Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life, DO NOT use retired) (Specify only highest grade completed) rould be filed within 72 Ind Mental Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) 5+ Baltimore city schools administrator Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ္ Roberta Eliza Presbury Caleb Washington Gwynn should by and Me 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 738 Park Avenue Hoboken, NJ 07030 19a. Informant's Name/Relationship (Type, Print) permit. Page 1 and 2 sh.
Department of Health an
Important: If item 27 is
any injury or other trau Fletcher Roberts/son 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 D Burial 2 Cremation 3 Removal from State 4 X Donation 5 Other (Specify) Signature of Funeral Service ROTTa Ld State മെറിയിലാണ്യം Board 655 W. Baltimore Street 21201 Baltimore, MD Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, r heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final multi boban Physician/ numonia disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions. Examine it any, leading to immediate cause. Enter Underlying Oue to for as a consequence of burial-transit Cause (Disease or iinjury that initiated events Due to (or as a consequence of) resulting in death) Last attending physician Physician/Medical P.O. Box 68760 the as IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Day in the past 12 months? Month Year 5 Other (specify) Pregnant at time of death signed by the at d be detached for 1 Yes 2 L 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by 2 No 3 ☐ Probably 4 ☐ Unknown Records, 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy certificate has death? 1 ☐ Yes 2 ☐ No To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certific **Division of Vital** 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Hospital: Other: 1 Yes 2 No ၣ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) filled in by the funeral Manner of Death 28b. Time of Certificate: 28c. Injury at 28d Describe how injury occurred work? iniury 1 Natural 5 Pending Accident Investigation Suicide Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one 29b. Signature and title of certific 29c. License number 29d. Date signed (Month, Day, Year) AT 243-8946C3 M.D APRIL, 6, 2011

State Registrar

DHMH 17 Rev 7/2009

UNION

. Registrar's Sign

MEMORIAL HUSPITAL

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

BILAL

2011

31. Date filed (Month, Day, Year)

APR 14

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			For State Registrar		State of Ma	aryland		rtment of F tificate of L			giene 0	Description of the second	12040	
	Physicia	n/	Decedent's Name (Fire	rst, Middle, Last)					2. Date of De	ath	Year	3. Time of Death	
*****	Medic	al	R.E. REEI		street and number			4h Oit Tours a	. I anation of Dooth	APRIL 9	<u> </u>		10:15p ^M	
-	Examin	er	,	. 5	ICE CENTER	₹		TOWSO	r Location of Death ${ m N}$	1	1	ty of Death LTIMORE		
	Funeral Director		5. Social Security Number 428-20-49	13	X XXM 2 □ F 7. Age	(In yrs. last	<i>birthday)</i> Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Bir	h 1 922		place (State or Foreign	
	d d		Usual Residence of Dec			10c. City, T	own or Lon	ation	·	-		14	0d. Inside City Limits	
	arylan ka-fsh ified a	ecto	MD.	N/A		3.	LTIMO					I.	1 XYes 2 No	
	the M	۵	10e. Street and Number	N/A		DA	LITIO	10f. Zip Code			10g. Citizen of	What Cour	itry?	
	h with	The state of the s												
336	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Department of Health and Mental Hyglene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show amy follury or other traumatic event, the Medical Examiner must be notified at once.	Completed by Fu	11. Marital Status1 ☐ Never Married3 ☒ Widowed 4 ☐	2 Married	12. Was Decedent E Armed Forces? 1 X Yes 2 1 If Yes, Give Year or Dates.		If	/as Decedent of H Yes, specify Cuba ☐ Yes 2X No	n, Mexican, Puerto	pecify Yes or No- po Rican, etc.)	Bla	14. Race - American Indian, Black, White, etc. Specify: BLACK		
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Maryland	2 shou th and 7 is m traum	-	19a. Informant's Name/			- 1			and Number or Ru		-			
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mo	Page nent o ant: If ant: If ary or	Ц	1 XBurial 1 C 4 Donation 5 D		Removal from State)			atory or other place RK CEMET	ERY 4-1	5-2011	BALTIMO	RE, M	1ARYLAND	
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68760	rtificate ing phy e as th	Med	IF FEMALE:											
Вох 6	ath certific attending p	cian/	23b. Was decedent preg in the past 12 mont	ths?	3c. If yes, outcome o? 1 ☐ Live Birth 4 ☐ Pregnant at	2 🗌 Fetal de	eath 3 🗌	Ectopic pregnand Other (specify)	У			ate of delive onth	ery Day Year	
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alF	sician: The certificate rector, pag	BeC	25. Was case referred to examiner?					26. PI	ace of Death (Che	1 L Yes	2 No	1 Yes	2 🗆 No	
of Vital	Physician: T r this certifica ral director, p	ျာ	1 Yes 2 2000	<u> </u>	lospital: 1 Inpatie	ent 2 ER	Outpatient		4 ∐ Nursing H	lome 5 Resid			Hospice	
0 U	ding l tth. : After e funer	cate	/ X .	Pending Investigation	(Month, Day,		injury	28c. Injury work M 1	yat ? Yes 2 □ No	28d. Describe h	ow injury occun	red		
Division	al or Attending P s after death. I Director: After t d in by the funera	Certificate:		Could not be determined	28e. Place of Injui		, farm, stre	et, factory, office		28f. Location (S	Street and Numb	er or Rural	Route Number,	
Ö	pital o		00.00.00	2 111 11 11										
	To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director. After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transic.	Medical	(Check 2 🛶	Medical Examin	cian: To the best of r er: On the basis of ex Practioner: To the b	amination ar	nd/or investi	gation, in my opinio	on, death occurred	at the time, date a	nd place, and du	e to the ca	use(s) and manner stated.	
_	To th withii To th comp		29b. Signature and title)		3-,-	29c. License			29d. Date signe			
			Poce	00	elula	Ch	10	KKI	3356		HPNI	10	3011	
1			30. Name and address of	of person who co	ompleted cause of de	eath (Item 23	Sa) (Type, Pr	Tauso	ntawn	RIVE	Tous	an N	Daiard	
	Stat Registra	•	31. Date filed (Month, Da	R 1 4 20	32. Fegistra	r's Signature	1. 1	arkel						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

ric Robinson	State of Maryland / 1-For State Registrar	Certificate of		iygiene _{Reg.}	2U11	12041						
	Decedent's Name (First, Middle, Last)			Date of Death Month Death	ay Year	3. Time of Death 0509 hrs						
Madical Examiner	Eric Cloud Robinson 4a. Facility Name (if not institution, give street and number)		b. City, Town, or Location of Dea	April 10, 201	1 4c. County of Death	0009 1113						
	Bon Secours Hospital		N/A									
Funeral	5. Social Security Number 6. Sex 7. Age ((In yrs. last birthday)	If Under 1 Year If Under 24H		`							
Director	217-52-6343 1xm 2 F	59 Yrs.	Months Days Hours Mi	08/29/	/1951 Foreign	ntry) MD						
Ď.	Usual Residence of Decedent 10a. State 10b. County 11	Oc. City, Town or Locati	on	10d. Inside City Limits								
p was _	MD N/A	•	imore			1 X Yes 2 No						
Maryland 28a-f shnw d at once.	10e. Street and Number	Baic	10f. Zip Code	10g.	Citizen of What Coun	Citizen of What Country?						
the M triffed Dire	1217 W. Fayette St.		21223	τ	J.S.A.	I.S.A.						
r death with the Maryland or teems 23s nr 28s-f shu must be notified at once. Funeral Director	11. Marital Status 1 Never Married 2 Married Armed Forces?		Decedent of Hispanic Origin? (Ses, specify Cuban, Mexican, Puerl		14. Race - Americ White, etc.	an Indian, Black,						
5	1 Yes 2 3 Widowed 4 Divorced If Yes, Give Year	X No 1	Yes 2 No specify:		Specify:Black							
3 72 hours after death with the Maryland 72 hours after death with the Maryland al Examiner must be notified at once letted by Funeral Director	15. Decedent's Education (Specify only highest grade compl	leted) 16a. Decedent	's Usual Dccupation (Give kind of		6b. Kind of Business/Ir	ndustry						
6 72 ho ral En	Elementary/Secondary (0-12) College (1-4 or 5+	·) during mo	est of working life. DO NOT use re	urea)								
15-0036 filed within 72 hours aft Hygiene, of other than "matural" t, the Medical Examine e Completed by	12th Grade 17. Father's Name (First, Middle, Last)	Labore	18.Mother's Nam	ne (First, Middle, Mai	Lexington den Surname)	Market _						
21215-0036 suld be filed within 7 Mental Hygiene Hygiene ic event, the Medica TO Be Comple	Lorenzo Robinson											
2121 bould be find Mental is marked atte event, To Be	LORENZO ROBINSON Bertha Arvin 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip											
Baltimore, MD 2 permit. Pages I and 2 shoul Department of Health and Is Important: If Item 27 is in injury or other fraumatic	Delores Robinson(Aunt) 20a. Method of Disposition	913 (20b. Place of Disposi	Granby St B	altimore Date 2	MD 21.2	0 2 Fown, State						
Baltimore, pernit. Pages 1 ar Department of Hea Important: If the Injury ar ather fr	1 Burial 2 Cremation 3 Removal from State	e crematory or oth		, ,								
litin nit. Pe artmet sortan vy ur	4 Donation 5 Other Specify: 21. Signature of Funeral Service Licensee		TEMATOLY 1-47		Baltimore							
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Physician //Medical	23a. Part I. Enter the disease, or complications that caused th failure. List only one cause on each line.				, shock, or heart	Approximate Interval Between Onset and Death						
£xaminer	Immediate Cause (Final disease or condition resulting in death) Due to (or as a consequence)		e Pulmonary Dis	ease		Death						
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he death certificate the death certificate by the attending phyched for use as the Physician/M	past 12 months?		al death 3Ectopic pregr er (Specify)	nancy	Month D	ay Year						
BO) e death the att	1 Yes 2 No 9 Unknown 9 Unknown	contract of the second										
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Records, F The law requires freate has been sig page 2 should be Completed				24a. Was an	24b. Were aut	opsy findings available ompletion of cause of						
ecol ne law te has l ge 2 sh				autopsy performe 1 ✓ Yes 2	ed? death?	·						
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Division of Vital Records, tal or Attending Physician: The law requir rs after death. The Directur: After this certificate has been seled in by the funeral director, page 2 should bettiffication: To Be Completed.	27. Manner of Death 1 X Natural 5 Pending 28a. Date of Injury (Month, Day, Year	28b. Time of Ir	njury 28c. Injury at Work?	28d. Describe hov	v injury occurred							
Division o spital or Attending tours after detah. neral Directur: Aft filled in by the fune Certification:	2 Accident Investigation	ry - At home, farm, stree	t, factory, office building, etc.		eet and Number or Ru	al Route Number, City						
Div Division of Carlo of Carlo of Filled in Certification of Certification	4 Homicide determined (Specify)			or Town, Stat	θ)							
	29a. Certifier (Check only one) Certifying Physician: To the best of my leading to the basis of examiner: On the basis of examiner.	knowledge, death occur	red at the time, date and place, ar	nd due to the cause(s	s) and manner as state d place, and due to the	ed. e cause(s)						
To the Hu within 24 To the Fu complete!	and manner stated. 29b. Signature and title of certifier		29c. License number		9d. Date signed (Mon							
	DA . A. PROD) ,	O.C.M.E.	,	April 10, 2011							
	30. Name and address of person who completed cause of dea											
1			111 Penn Street, Baltimo	ore, MD 21201								
State	31. Date filed (Month Carl Year) 2011 32. Segistrate	s signature										

		State of Manyland / Department of Health and	-	_	
		1- For Amend Items 28a, b, c, per dr., g, 14,04/14/2011 dib	Reg. N	2011	12042
Physi /Med		Fregerick Hiexander Siminons	Hp(113,	AO II C. County of Death	3. Time of Death 6:30 P M
Exam	iner	Long Green Center Nursing Home Battimore	1 • 4	c. County of Death	
Funera Directo	1	5. Social Security Number 6. Sex 7. Age W yrs. last birthday) If Under 1 Year I If Under 24 Hrs. Months Days Hours Min. Usual Residence of Decedent	8. Date of Birth (Month, Day, Yea 6-22-19	9. Birth Cou	place (State or Foreign ntry)
aryland show	7	10a. State 10b. County 10c. City, Town or Location			10d. Inside City Limits 1 ∰Yes 2 ☐ No
n the M r 28a-f r notifie	Director	10e. Street and Number 10f. Zip Code	10g. C	Citizen of What Cou	ntry?
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Maryland of 2 should be file the and Mental H to marked oth	-	19a Informant's Name/Relationship (Type. Print 5 Ser) 19b. Mailing Address (Street and Number or An	ral Route Number, City	• • • •	p Code)
es 1 and 2 of Health		20a. Method of Disposition 20b. Place of Disposition (Name of Cemetery, crematory or other place)	Date 20c.	Location - City or T	own, State
Page nent a		4 Donation 5 Dother (Specify)	11-11 Be	altimor	e m
Balti permit. Departr Importa any inju		21. Signafre of Funeral Service Licensee 22. Nord of the Control	ene Func	21229)	vices
12.70		23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardia shock, or heart failure. List only one cause on each line.	c or respiratory arrest,		Approximate Interval Between Onset and Death
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Division or Vital Records, P.O. Box 687 To the Hospital or attending Physician: The law requires that the death certificate within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending phys completely filled in by the funeral director, page 2 should be detached for use as the	Physician/Medic	23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy 4 ☐ Pregnant at time of death 5 ☐ Other (specify)		23d. Date of deli	very Day Year
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Records, the law requires to the has been signed age 2 should be of	Completed	11/200101	24a. Was an	24h Were au	topsy findings available
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Division or Vital To the Hospital or Attending Physician: 1 Within 24 hours after death. To the Funeral Director: After this certificat completely filled in by the funeral director, p	Certification:	2 ☐ Accident investigation 3 ☐ Suicide 4 ☐ Homicide investigation 6 ☐ Could not be determined 28e. Place of injury - At home, farm, street, factory, office building, tc. (Specify)	28f. Location (Street City or Town, St	and Number or Ru ate)	ral Route Number,
To the Hospital or within 24 hours afte To the Funeral Dir completely filled in I	ical C	29a. Certifier (Check only (C	e, and due to the cause curred at the time, date	e(s) and manner as and place, and due	stated. to the cause(s)
To the within 2 To the somplet	Medical	one) and manner stated. 29b. Signature and title of certifier 29c. License number Doc	47056 29d.	Date signed (Manti	h, Day, Year)
A		> FENNEOL LINDAGECUPATTENDING DHYZICION	1	1141	1011
		30. Name and address of person who completed cause of death (Item 23a) (Type, Print) CENNEIT L(NDYBB225		- 1	-
S Regis	tate trar	1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1			

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

AMEND TTEM#25,27 perME, G9 14, 47 11/20 11 WS
State of Maryland / Department of Health and Mental Hygien 20 1 2043 1 - For State Registrar Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Month MAR(1) Year 2011 Physician/ M LON III SOMWARA GANESHWAR Medical 4c. County of Death 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** FRANKFOR 5009 Baltimore AAD FRANKFORD NUIZS & REHARS Baltimore 344 If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth Social Security Number Funeral 1**XX**M 2 □ F Days Hours Min 0272071982 Guyana 29 Director 215-37-0494 Usual Residence of Decedent show 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location **Funeral Director** 28a-f 1 Yes 2XXNo Maryland Baltimore Essex 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number ö 23a Guyana 21221 824 North Woodlynn Road Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. 11. Marital Status Armed Forces?

1 Yes 2 No 1 Never Married 2 Married þ "natural", or If Yes, Give Year or Dates 1 Yes 2 No Specify: Specify: East Indian Completed 3 Widowed 4 Divorced and Mental Hygiene.
is marked other than "natur aumatic event, the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business Industry Elementary/Seconday (0-12) College (1-4 or 5+) Automotive Detailer Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) 2 Page 1 and 2 should be f nent of Health and Menta Ahilia Harry Gooracknauth Somwara 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health a Important: If item 27 is any injury or other trau once, 824 North Woodlynn Road, Essex, Maryland 21221 Gooracknauth Somwara (Father) 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place)
Bayview Crematory, Inc. 04/02/2011 1 Burial 2XXCremation 3 Removal from State Baltimore, Maryland 4 ☐ Donation 5 ☐ Other (Specify) ^{22. Name and Address of Facility}
Bruzdzinski Funeral Home, P.A.
1407 Old Eastern Avenue, Essex, Maryladn 21221 21. Signature of Funeral Service Licenses Ja. Part 1, Epost the diese, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock in heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immedia Cause (Final diseas or condition resulting in death) SEPSIS SKNDROWE SEVERE Physician/ DAYS Medical Due to (or as a consequence of): **Examiner** BILATERAL if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Examine -transit PERSISTENT Due to (or as a consequence of): resulting in death) Last Physician/Medical TRAUMATIC WEUN IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death
4 Pregnant at time of death
9 Unknown 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?

1 Yes 2 No
9 Unknown Month been signed by the a should be detached f Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by et trochastic ch whites 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death?
1 □ Yes 2 ☒ No 24a. Was an autopsy Seizure 86 102 Rb Yes 2 XN Hospital or Attending Physician: 25. Was case referred to medical 26. Place of Death (Check only one) Certificate: To Be Other: 4 Nursing Home 5 - Residence 6 - Other (Specify) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at work? 1 ☐ Yes 2 ÅNo 28d. Describe how injury occurred injury NGGT TWEM 5 \square Pending DRIVING HOME FROM ESHING TRIP Hatural 2 Accident OCT 20,2008 Investigation 6 Could not be 3 Suicide 4 Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

STREET / ROWTE 702 & 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) 85558 × mD 855E.X Medical 1. X Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 3 only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) The kinddugan-D0040837 2011 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) # 308 Baltim or MD 21201 G KIDDUGAUN 821 NEWTAW 25 MOHAMMED 32. Registrar's Signature 31. Date filed (Month, Day, Year) State Registrar

DHMH 17 Rev 7/2009

Baltimore, Maryland 21215-0036

P.O. Box 68760

Records,

Division of Vital

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygienel For State Registrar Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) April **Physician** 2011 10:30 p™ William Richard Sherrill /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Prince Georges Bowie Larkin Chase Nursing and Rehab If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) 5. Social Security Number **Funeral** Days Months Hours 1**∑**M 2□F 83 May 23, 1927 Director 244-28-6945 North Carolina Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a State 10b. County marked other than "natural", or items 23s or 28s-f shov matic event, the McCleal Experiment out to notified at 1 ☐ Yes 2 No Director Maryland Prince Georges Mitchellville 10f. Zip Code 10q. Citizen of What Country? 10e. Street and Number 17750 Mill Branch Place 20716 USA Funeral 14. Race - American Indian, Black, White, etc. 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status 1 XYes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🔀 No Specify: · by WHITE 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) Interior Decorating 10th grade Interior Decorator 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Pages 1 and 2 should be f nent of Health and Mental ! Pauline Hodges Archie Sherrill 2 permit. Pages 1 and 2 shou Department of Health and M Important: If Item 27 Ie mar eny injury or other traumati once. 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 17750 Mill Franch Place, Mitchellville, MD 20716
ce of Disposition (Name of Date 20c. Location - City or Town, State Rosa Carbo Sherrill - WIFE 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 ☐ Burial 2 ☑ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Metro Crematory INC. 04-13-2011 Baltimore, Maryland Signature 22 Name and Address of Facility Cremation Society Of Maryland INC of Funeral Service Digensee Patrik Fleming 299 Frederick Road, Baltimore, Maryland 21228 Demise Tart1. Enter the disease, or complications that a used the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on, ach line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Heart Physician カイヤル /Medical Due to (or as a consequence of): Examiner ander my Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of Examiner Aor The law requires that the death certificate be executed the that initiated events resulting in death) Last Due to (or as a consequence of) attending physician a for use as the burial-Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 3 DEctopic pregnancy 2 Fetal death 1 Live birth Month in the past 12 months? 4 Pregnant at time of death 5 Other (specify) signed by the a 9 Dinknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. à 1 Yes 2 No 3 Probably 4 Property Bronchite Completed peeu 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performed' 2□ No 1 Yes certificate to talic 1 Yes 20 25. Was case referred to medical examiner? 26. Place of Death Check only one Be Hospital: 1 | Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 2 2 ER/Outpatient 3 DOA this 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28d. Describe how injury occurred 28b. Time of Certification: After Injury 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident Director 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) in by t 4 - Homicide To the Funeral 1 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. cal 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 24 ihe edi 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier 00051437 0+1 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) FAIRWOOD INTERNAL MEDICINE

DHMH 17 Rev 1/2001

State Registrar

ORIGINAL

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32. Pegistrar's Signature

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31. Date filed (Month, Day, Year) APR 1 4 2011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			1 - For Amend Items 25 State Registrar	5\$t a te 28 Ma	ryland / Depg Cer	tificate of Death		giene Reg. No.?	12065			
	Physicia	an/	1. Decedent's Name (First, Middle, Last)				2. Date of Dea	ath Day Year	3. Time of Death 7:10A M			
	 Medic Examir 	cal	MATIE 4a. Facility Name (if not institution, give st	reet and number)	SUTHER	4b. City, Town, or Location		eath 4c. County of Death				
1			MORTH WEST 5. Social Security Number 6. Sex	HOSP	(In yrs. last birthday)	RANDALI If Under 1 Year If Under						
	Funeral Director		084 - 22 - 1833	1	107 Yrs.	Months Days Hours		n. (Month, Day, Year) Country)				
	and show lat	'n	Usual Residence of Decedent 10a. State 10b. County		10c. City, Town or Lo				10d. Inside City Limits			
	Maryla 28a-f	Director	MD Baltimo	re	Rand	dallstown			1 🗆 Yes 🗚 No			
	1 and 2 should be filed within 72 hours after death with the Maryland of Health and Mental Hygiene. Item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at	Funeral D	10e. Street and Number 3926 Nemo Road			10f. Zip Code 21133		10g. Citizen of What Cou U . S . A				
	r items		11. Marital Status 1 1 Never Married 2 Married	2. Was Decedent E Armed Forces?	l l	Vas Decedent of Hispanic Orl f Yes, specify Cuban, Mexicar	gin? (Specify Yes or No- n, Puerto Rican, etc.)	14. Race - Ameri Black, White,				
21215-0036	ırs after ural", o I Exam	ed by	3X Widowed 4 □ Divorced	1 ☐ Yes 2 XI If Yes, Give Year or Dates.	1	Yes 2 No Specify:		Specify: B	lack			
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	l within ygiene. her tha it, the N	Be Cor	8th grade	College (1-4 or 5- na	H)	ousekeeper		Privat	е			
Maryland	e should be filed v h and Mental Hyg 7 is marked othe traumatic event,	To B	17. Father's Name (First, Middle, Last)			18. Moth	er's Name (First, Middle, :	Maiden Surname)				
Aary	should and M is mai raumat		19a. Informant's Name/Relationship (Type	e, Print)	11.	ng Address (Street and Number						
	le 1 and 2 st of Health If item 27 or other tr		Phillip Green-S 20a. Method of Disposition	on	20b. Place of Dispo		Randallst	20c. Location - City or T				
altimore,	0		1 → Burial 2 ☐ Cremation 3 ☐ R 4 ☐ Donation 5 ☐ Other (Specify)	emoval from State	King Mer	natory or other place)	3/25/201	25/2011 Woodlawn, Md				
Balt	permit. Page Department Important: I any injury or once.		21. Signature of Funeral Service Licensee	Kreke	, Mã	Name and Address of Facility Arch F/H Wes 300 Wabash A	št Ave, Balti	.more, Md	21215			
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	Examiner	er	. Sequentially list conditions									
	ted d unsit	Examine	if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury	Due to (or as a	consequence of):		0 1M	ENVAL EXAMINER				
	ate be executed physician and the burial-transit	al Ex	that initiated events c resulting in death) Last	Due to (or as a	consequence of):	CERT	FICATION APPROVED BY	NEDICAL EXAMINATION				
120	ficate by g physical as the b	l edical	d			OEK.						
Box 687	eath certific attending p I for use as	Physician/M	IF FEMALE: 23b. Was decedent pregnant in the past 12 months?		2 🗌 Fetal death 3 🗔			23d. Date of delive	very Day Year			
). Bo	that the deaned by the and detached for	hysic	1 Yes 2 No 9 Unknown	4 ☐ Pregnant at 9 ☐ Unknown	time of death 5 L	Other (specify)		WOTH	Day 1623			
, P.O.	The law requires that the death certificate be executed ate has been signed by the attending physician and page 2 should be detached for use as the burial-transi	<u>م</u>	Part II. Other significant conditions conf	-	t not resulting in the u	nderlying cause given in Part		obacco use contribute to t				
ords	v requir s been s should	Completed					24a. Was a	an 24b. Were auto	ppsy findings available			
Rec	The law cate has page 2 t	Com					autop perfo	rmed? death?	ompletion of cause of			
/ital	sician: The certificate irector, pag	Be	25. Was case referred to medical examiner? 1 Yes	ospital:		Other:	th (Check only one)					
Division of Vital Records,	To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certific completed filled in by the funeral director,	te: To	27. Manner of Death	28a. Date of injury	nt 2 ER/Outpatien y 28b. Time of injury	28c. Injury at	28d. Describe h	lence 6 □ Other (Specif ow injury occurred t slipped ar				
sion	Attendir death.	Certificate:	2 Accident Investigation 3 Suicide 6 Could not be 4 Homicide determined	(Month, Day, 02/12/20	y - At home, farm, stre		No of cha	air				
Div	ital or, urs afte ral Dire			building, etc.			Randalls	treet and Number or Rura n, State) 3926 Ne stown, MD	mo Road			
	re Hosp n 24 ho e Fune pleted fi	Medical	(Check 2 Medical Examine	r: On the basis of ex-	amination and/or invest	occured at the time, date and igation, in my opinion, death or death occurred at the time, date	curred at the time, date a	nd place, and due to the ca	ause(s) and manner stated.			
	To the I within 2 To the I complete	_	29b. Signature and title of vertifier	11		29c. License number		29d. Date signed (Month,				
	(2)		30. Name and address of person who con	npleted cause of de	ath (Item 23a) (Type, P			MARCH 20				
			LEONARD RICHAMSO	N M.p. 1	838 GRE	ENE TREE ROA	1P#300 Pil	LESVILLE MO	21208			
	Stat Registra	e ar	31. Date filed (Month, Day, Year) APR 1 3 2011	2. Registrar	S. Signature	Kel						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day **Physician** DONNTAG OL :10 2011 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner BACTIMORE NURSING KNerview Lome If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number If Under 1 8. Date of Birth (Month, Day, Year) 6. Sex 7. Age (In yrs. last birthday) **Funeral** 1 □ M 2 X F Months Days Hours Min. 215-28-1236 Director 03-13-1929 VIRGINIA Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene. ant of Health and Marked other than "natural", or Items 23a or 28a-f show 10b. County 10c. City, Town or Location 10d. Inside City Limits 10a State permit. Pages 1 and 2 should be filed within 72 hours after death with the Mar. Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f shary injury or other traumatic event, the Wedical Examination until be notified. 1√Yes 2 No Funeral Director Baltimore UNDALK 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 51993 2634 Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No
If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 □Yes 2 No Specify: White Specify. ģ 3 Widowed 4 Divorced Year or Dates: Be Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) BANKING 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) ဂ DONNTIAC 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) (NIFER) St. Leginko, MD 20c. Location - City or Town, State View LANC LIMber Denise 20a. Method of Disposition
1 ☐ Burial 2 A Cremation 3 ☐ Removal from State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 14-2011 4 □ Donation 5 □ Other (Specify) FUNCEALLOINEPA. RALY LIGITIES FOR FOR Signature of Funeral Service Ligense 22. Name and Address of Facility 1)SHIZH Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, be find to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, physician Physician/Medical IF FEMALE 23b. Was decedent pregnant in the past 12 months? ves, outcome of pregnancy 23d. Date of delivery 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 3 Ectopic pregnancy Day 5 ☐ Other (specify) ☐Yes 2☐No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 2 🗌 No 3 Probably 4 Unknown 1 Tes 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy certificate 1 ☐ Yes 2 ☐ No 2 No 1 ☐ Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 | Yes 2 N No Certification: To 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA After this 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural
2 Accident 5 Pending investigation Il Director: A 1 ☐ Yes 2 ☐ No 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) within 24 hours after d To the Funeral Direct completely filled in by i determined 4 ☐ Homicide the Hospital 1 🖟 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) ē 29b. Signature and title of certifier 29c. License number MI-D 69540 2011 12 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) illy 8813 Wal Man 204 Parkir le Suite Shah 31. Date filed (Month, Day, Year) 32. Registrar's Signature State 1 4 2011 Registrar

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. For State Registrar State of Maryland / Department of Health and Mental Hygiener Certificate of Death Reg. No. Decedent's Name (First, Middle, Last) Date of Death 3. Time of Death Month. Physician/ 10:41 AM aori Medical Facility Name (if not institution, give street and number) 4b. City-Town, or Location of Death **Examiner** Himore Naris imonium 5. Social Security Number 219-62-1752 If Under 1 Year If Under 24 Hrs 9. Birthplace (State or Foreign Country) rs. last birthday) 8. Date of Birth **Funeral** 120-20-1956 1**∕** M 2 □ F Days Months Hours **Director** Usual Residence of Decedent item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at 10b. County 10d. Inside City Limits should be filed within 72 hours after death with the Maryland and Mental Hygiene. 10c. City, Town or Location Director timore 1 🛩 Yes 2 🗆 No 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? Funeral 21223 Baltimore Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12, Was Decedent Ever in U.S. 14. Race - American Indian. 11. Marital Status Armed Forces?

1 Yes 2 No Black, White, etc. þ 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 No Specify: Blac If Yes, Give Year or Dates Specify: Completed 3 Widowed 4 Divorced 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life, DO NOT use retiled) (Specify only highest grade completed) onday (0-12) College (1-4 or 5+) het Be ၉ ship (Type, Print) 19b. Mailing Address (Street and Number or Rural Ro permit. Page 1 and 2 sk Department of Health ar Important: If item 27 is Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 1 Burial 2 Cremation 3 Removal from State 5 4 Donation 5 Other (Specify) 21. Signal re of Funeral Service Licenses 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or hear failure. List only one cause on each line. Immediate Cause (Final Onset and Death Physician/ iver disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, Examine if any, leading to immediate cause. Enter Underlyin Cause (Disease or linjury Due to (or as a consequence of): the Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): signed by the attending physician a d be detached for use as the burial-Physician/Medical Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No Other (specify) 1 Yes 2 g Unknown g Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 2 No 3 Probably 4 Unknown 1 Tyes 24b. Were autopsy findings available 24a. Was an prior to completion of cause of death? has autopsy performs 2 🗆 No 1 Tyes Division of Vital 25. Was case referred to medical Certificate: To Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 2 1 Inpatient 2 ER/Outpatient 3 DOA 6 Other (Specify within 24 hours after death.

To the Funeral Director: After this completed filled in by the funeral 27. Manner of De th 28a. Date of injury 28b. Time of 28c. Injury at 28d. Describe how injury occurred (Month, Day, Year) injury 1 Natural 5 Pending work' 1 Tes Accident Investigation 6 Could not be Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one 29b. Signature and 🐠 29d. Date signed (Month, Day, Year) person who completed cause of death (Item 23a) (Type, Print) 32. Registrar's Sig State Registrar

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month April Physician/ 2011 3:00 AMAlfredo Cuatro Solorzano Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Sanctuary At Holy Cross Burtonsville Montgomery If Under 1 Year | If Under 24 Hrs 8. Date of Birth (Month, Day, July 28, 9. Birthplace (State or Foreign Social Security Number 7. Age (In yrs. last birthday) **Funeral** 1 X M 2 □ F Salvador Director 578-72-8917 88 E1 Usual Residence of Decedent ms 23a or 28a-f show must be notified at permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho any injury or other traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 X No MD Howard Laurel 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? by Funeral 9633 20723 USA Norfolk Avenue Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, 11. Marital Status Armed Force 1 Never Married 2 Married 1 ☐ Yes If Yes, Give Baltimore, Maryland 21215-0036 1 K Yes 2 □ No Specify: El Salvadorian Specify: Hispanic 3 X Widowed 4 ☐ Divorced Completed Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15 Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Office Buildings Maintenance Man 1st Ø Be 17, Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Cristina Solorzano Alejandro Cuatro 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Laurel, 20723 Isabel C. Delarosa/Daughter 9633 Norfolk Avenue, MD20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Date 1X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) MD National Mem. Pk 4/8/2011 Laurel, MD Donaldson Funeral Home, P.A. Signature of Funeral Service Licenses 22. Name and Address of Facility M01103 20707 313 Talbott Avenue, Laurel, 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition Ph_sician/ Medical resulting in death) Due to (or as a contequence of): Examiner Sequentially list conditions, Physician/Medical Examiner If any leading to immediat cause. Enter Underlying the Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or linjury that initiated events and Due to (or as a consequence of) resulting in death) Last ate has been signed by the attending physician page 2 should be detached for use as the burial Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) ____ in the past 12 months?

1 Yes 2 No Month Day Year 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an within 24 hours after death.

To the Funeral Director: After this certificate has autopsy performed 1 Yes 2 No 25. Was case referred to medical completed filled in by the funeral director, Be 26. Place of Death (Check only one) examiner? Other: 2 No ျ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Mannes of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: 5 Pending 1 Natural 1 🗌 Yes 2 No Accident Investigation 6 Could not be Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Signature and title of certifier 29d. Date signed (Month, Day, Year) Doo 69829 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Smith Ave., Suite 203 2835

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ April 9, Day 011 Gerald Augustus Stone, Sr. 11:00 PM Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death Baltimore 308 Waveland Road Catonsville Social Security Number If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign **Funeral** 7. Age (In yrs. last birthday) 8. Date of Birth Country)
Maryland 1 X M 2 - F (Month, Day, Year) 5/18/1914 96 **Director** 216-03-8235 Usual Residence of Decedent 28a-f show permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho any injury or other traumatic event, the Medical Examiner must be notified at 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 🗌 Yes 2 🂢 No Baltimore Catonsville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 308 Waveland Road 21228 USA 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. þ 1 Never Married 2 Married 1 ▼ Yes 2 No If Yes, Give Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: White Completed 3 X Widowed 4 ☐ Divorced Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Retail Sales Sales Manager Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Albert Stone Fay A. Younkins 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 106 Wye View Road, Queenstown, Maryland 21658 Sharon J. Lippert / Daughter 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place, 1 Burial 2 X Cremation 3 Removal from State Bayview Crematory 4/12/2011 Baltimore, Maryland Donation 5 Other (Specify) 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Hubbard Funeral Home, Inc. 4107 Wilkens Avenue, Baltimore, Maryland 21229 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of) Exami Cause (Disease of impury that initiated events resulting in death) Last The law requires that the death certificate be executed Due to (or as a consequence of) attending physician for use as the buria Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months? Month Day Year g 🗌 Unknown g Unknown ed by the Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Records, 1 Yes 2 No 3 Probably 4 Unknown Completed After this certificate has been s funeral director, page 2 should Were autopsy findings available prior to completion of cause of 24a. Was an autopsy performed? Yes 2 No death? 1 ☐ Yes 2 ☐ No To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifica completed filled in by the funeral director, I Be 25. Was case referred to medical 26. Place of Death (Check only one) 2 [ျှ 1 🗌 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Besidence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: injury work? 1 ☐ Yes 2 ☐ No Natural 5 Pending Accider
Suicide Accident Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, determined City or Town. State) Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifie (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

State Registrar

only one 29b. Signatur

31. Date filed (Month

30. Name a

Box 68760

P.O.

Division of Vital

500

ma

address of person who completed cause of death (Item 23a) (Type, Print)

29c. License number

2006 1159

29d. Date signed (Month, Day, Year)

4-11-11

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No.-1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ April 12, 2011 Year Esther Stata 4:45 Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death County of Death Montgomery 9615 Dewitt Drive #A-103 Silver Spring 5. Social Security Number 6. Sex If Under 1 Year If Under 24 Hrs 8. Date of Birth (Month, Day, Ye April 28, **Funeral** 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign Year) 19<u>38</u> 1 M 2 X F Days Hours Min. Canada **Director** 567-68-6354 Usual Residence of Decede works 10a. State 10b. Count 10c. City, Town or Location Director 10d. Inside City Limits notified 28a-f 1 Yes 2X No Maryland Montgomery Silver Spring ò 10e Street and Number 10f. Zip Code 10g, Citizen of What Country? must be Funeral 23a 20910 9615 Dewitt Drive #A-103 Canada items 2 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Bace - American Indian event, the Medical Examiner Black, White, etc. 1 ☐ Yes 2 💆 No If Yes, Give Year or Dates. ö ģ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: 'natural", 3 ¥ Widowed 4 □ Divorced Completed White 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) permit. Page 1 and 2 should be filed within 72 Department of Health and Mental Hygiene. Important: If item 27 is marked other than 'any injury or other traumatic event, the Me Elementary/Seconday (0-12) College (1-4 or 5+) Legal Assistant Insurance Be 17. Father's Name (First, Middle, Last, 18. Mother's Name (First, Middle, Maiden Surname) ည Lillian Doyon Raoul Gagne 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3216 Coquelin Terrace, Chevy Chase, Maryland 20815 Diane Stata / Daughter 20b. Place of Disposition (Name of cemetery, crematory or other place)
Montgomery
Crematorium, Inc. 20a. Method of Disposition 20c. Location - City or Town, State April 14. ☐ Burial 2 🖾 Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Bethesda, Maryland 2011 21. Signature of Funeral Service Licen-Robert A. Pumphrey Funeral Home/Bethesda-Chevy Chase, Inc. DA M01360 7557 Wisconsin Avenue, Bethesda, Maryland 20814-3501 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Immediate Cause (Final Physician/ 14 Months disease or condition resulting in death) Lung Cancer Medical Due to (or as a consequence of) Examiner Years Smoking Sequentially list conditions Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Due to (or as a consequence of) and -transit that the death certificate be executed g physician and the burlal-t resulting in death) Last Due to (or as a consequence of): Physician/Medical Box 68760 attending phase as the IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent precnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months? Pregnant at time of death Month Day Year 9 Unknown 9 Unknown P.O. signed by the period of the period of the signal of the si Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Records, Completed 1 X Yes 2 □ No 3 □ Probably 4 □ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 s has autopsy performed 1 ☐ Yes 2 ☐ No 1 Yes 2 X No of Vital To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifica completed filled in by the funeral director; 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 🕅 Residence 6 Nother (Specify) 2 X No 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred X Natural iniury 5 Pending Division 1 Yes 2 No ☐ Accident ☐ Suicide Investigation
6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number 4 Homicide determined Medical 29a. Certifier X Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Pranticions: To the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check enty end 29b. Signature and title of contifier 29c. License number 29d. Date signed (Month, Day, Year) April 12, 2011 D47794 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DHMH 17 Rev 7/2009

State

Registrar

Karen R...Rabin, M.D.

APR 14

parkel

10810 Connecticut Avenue, Kensington, Maryland 20895

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day 20<u>11</u> Physician/ April Beatrice Siegel 2:34 P M 11 Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death **Examiner** Chevy Chase Montgomery 8100 Connecticut Avenue, #608 Social Security Number 6. Sex If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign 7. Age (In vrs. last birthday) **Funeral** Min. Months 98 073-14-6442 September 16, 1912 New York Director Usual Residence of Decedent show 10a. State 10b. County ral", or items 23a or 28a-f shor Examiner must be notified at 10c. City, Town or Location 10d Inside City Limits Director Chevy Chase Maryland Montgomery 1 Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? with 1 Funeral 8100 Connecticut Avenue, #608 20815 United States 72 hours after death 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, 11. Marital Status Armed Forces? Black, White, etc. ģ 1 Never Married 2 X Married Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: If Yes, Give Year or Dates Specify: White "natural", 3 Widowed 4 Divorced Completed permit. Page 1 and 2 should be filed within 72 hour Department of Health and Mental Hyglene. Important: If item 27 is marked other than "natu any injury or other traumatic event, the Medical any injury or other traumatic event, the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) College (1-4 or 5+) Elementary/Seconday (0-12) Writer/Author Literature Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 0 Sophia Kopp Samuel Jacobson 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 8100 Connecticut Avenue, #608, Chevy Chase, MD 20815 Samuel Siegel/Husband 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Aprilate13. cemetery, crematory or other place)

Cemetery

Cemetery 1 X Burial 2 Cremation 3 Removal from State y 2011 Flushing, New York

22. Name and Address of Facility Kobert A. Pumphrey Funeral Home/
Bethesda-Chevy Chase
Bethesda, Maryland 20814 4 ☐ Donation 5 ☐ Other (Specify) Signature of Funeral Service Licenses M01498 23a. Part 1, Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line. Immediate Cause (Final Physician/ disease or condition resulting in death) Urosepsis Medical Due to (or as a consequence of) Examiner Sequentially list conditions. Examine if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of) To the Hospital or Attending Physician: The law requires that the death certificate be executed use (Disease or linjury the burial-tran and that initiated events resulting in death) Last Due to (or as a consequence of): attending physician Physician/Medical Division of Vital Records, P.O. Box 68760 use as IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☒ No for Day Pregnant at time of death 5 Other (specify) 1 Yes 2 2 9 Unknown the a g Unknown signed by the Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Be Completed by Chronic Obstructive Pulmonary Disease 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🔀 Unknown page 2 should peen 24b. Were autopsy findings available prior to completion of cause of 24a. Was an Probable Alzheimer's Dementia certificate has autopsy performed? 1 Yes 2 X No death? 1 ☐ Yes 2 ☐ No completed filled in by the funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital: Other: မ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 X Residence 6 Other (Specify) After this 28a. Date of injury (Month, Day, Year) 28c. Injury at Manner of Death 28b. Time of Certificate: 28d. Describe how injury occurred work? 1 ☐ Yes 2 ☐ No 5 Pending injury 1X Natural within 24 hours after death.

To the Funeral Director: A Accident Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Medical 1 🔀 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) April 12, 2011 D55258

Registrar DHMH 17 Rev 7/2009

State

7758 Wisconsin Avenue, #211, Bethesda, Maryland 20814

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Gary Wilks, MD 31. Date filed (Month, Day, Year) APR 1 4

14

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Stephen Giles Strub	1- For State Registrar	State of Maryland / De C	partment of ertificate of		Re	201	12052	
Physician/ Madical Examiner	Decedent's Name (First, Mic	Stephen	Giles	Strub	2. Date of Deat Month April 8, 20	Day Year	3. Time of Death 1502 hrs	
	4a. Facility Name (if not institu 26 Kinsman View Ci		4	b. City, Town, or Location Silver Spring	of Death	4c. County of Death Montgomery		
Funeral Director	5. Social Security Number unk		s. last birthday) Yrs.	If Under 1 Year If Und Months Days Hour		h(MM/DD/YYYY) 9. Bir / 1956 Foreig Co	thplace (State or in NV untry)	
Ow any	Usual Residence of Decedent 10a. State 10b. Count MD	Montgomery 10c. c	ity, Town or Location	Silver Sp	ring		10d. Inside City Limits 1 Yes 2 XNo	
the Maryland n or 28a-f show tified at once. Director	10e. Street and Number 26 Kinsmar	View Circle		10f. Zip Code 20901	10	og. Citizen of What Coul USA	ntry?	
PL/ sr death with in or items 23. Funeral		Married 12. Was Decedent Ever in Armed Forces? 1 Yes 2 No ivorced If Yes, Give Year) If Ye	s Decedent of Hispanic Or ss, specify Cuban, Mexical Yes 2 No specify		White, etc.	ite	
5-0036 led within 72 hours after dygene. other than "natural" the Medical Examiner Completed by	15. Decedent's Education (Sp Elementary/Secondary (0-12 1 2	lor Dates: Decify only highest grade completed: College (1-4 or 5+)	during mo	's Usual Occupation (Give est of working life. DO NOT laims Adju	Tuse retired)	16b. Kind of Business/Industry Insurance		
1215-0 I be filed wiental Hygie arked other went, the M	17. Father's Name (First, Middl Giles Joser	h Strub			r's Name (First, Middle, M .eanor Jane			
MD 21 3 2 should th and Me a 27 is man to community or To		Strub/Brother	1634	Maddux La	mber or Rural Route Num ine, McLeai	n, VA 221	01	
IMOTE, Pages 1 an nent of Heal ant: If iten or other tra	20a. Method of Disposition 1 Burial 2 X remative 4 Donation 5 Other	on 3 Removal from State F	inal Jour	mey Crem.	3/15/2011	Woodbine,		
Balti permit. Departn Importi injury	Dou	e Licensee Dorota Mars			Cremation 13, Baltin		21203	
Physician Examiner	failure. List only one caus Immediate Cause (Final diseas			e mode of dying, such as	cardiac or respiratory arre	est, shock, or heart	Approximate Interval Between Onset and Death	
	or condition resulting in death) Sequentially list conditions,	Due to (or as a consequence						
ted Insit Examlner	if any, leading to immediate cause. Enter Underlying Caus (Dissass or injury that initiated	С.						
iO, e be executed ysician and burial - transit	events resulting in death) Last	d. AMENDED 23a,27	·	~015 5 2 11				
60, rate be execut obysician and ne burial - tra	IF FEMALE:	23c. If yes, outcome of pr		8917 7-7-11	VL	23d. Date of delivery	,	
. Box 68760 the death certificate I by the attending phys ched for use as the bh Physician/Me	23b. Was decedent pregnant in past 12 months? 1 Yes 2 No 9 U	4 Pregnant at time of	death -	al death 3 Ectop	ic pregnancy	Month E	Day Year	
ords, P.O. we requires that the as been signed by the should be detache	Part II. Other significant cond	itions contributing to death but no	t resulting in the u	ndertying cause given in P		bacco use contribute to		
Rec The la ccate h					24a. Was a autops perform	sy prior to o med? death?	topsy findings available completion of cause of	
F Vital Physician: r this certif ral director, To Be (25. Was case referred to medic examiner? 1 Ves 2 No	Hospital: 1 Inpatient 2	ER/Outpatient		(Check only one) Nursing Home 5 1	Residence 6 🗸 Other	: Scene	
ion of tending Pheath. On: After the funeral ation: T	27. Manner of Death 1 X Natural 5 Per	28a. Date of Injury (Month, Day, Year) ading estigation	28b. Time of In	jury 28c. Injury at Wor 1 Yes 2	_	ow injury occurred		
Division o To the Hospital or Attending within 24 hours after death. To the Funeral Director: After completely filled in by the fune	3 Suicide 6 Co		t home, farm, stree	, factory, office building, e	etc. 28f. Location (S or Town, St	treet and Number or Ru ate)	ral Route Number, City	
To the Host within 24 hd To the Fun completely:	(Onton only	Physician: To the best of my knowl aminer:On the basis of examination and manner stated.	-					
To vitil To com	29b. Signature and title of certification			29c. License number O.C.M.E.		29d. Date signed <i>(Mo</i>	nth, Day, Year)	
	30. Name and address of personal Margarita Korell MD.	n who completed cause of death (It Assistant Medical Exam		enn Street, Baltimore	e, MD 21201	<u> </u>		
State Registrar								

DHMH 17 Rev 1/2001

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend #10e&f Per ANA BD G915 5/02/2011 JH State of Maryland / Department of Health and Mental Hygien

for State Registrar Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Day 2011 Physician/ April 11, 5:50 AMM Joseph W. Sroka Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (if not institution, give street and number) **Examiner** Baltimore Gilchrist Hospice Towson 9. Birthplace (State or Foreign 8. Date of Birth If Under 1 Year If Under 24 Hrs Social Security Number . Age (In yrs. last birthday) **Funeral** (Month Day, Year) ug 27, 1953 Hours 1 🕅 M 2 🗆 F Pennsylvania 199-44-6893 57 Aug **Director** Usual Residence of Decedent 28a-f show 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County er than "natural", or items 23a or 28a-f sho the Medical Examiner must be notified at with the Maryland Director 1 ☐ Yes 2 🛣 No Lutherville MD Baltimore 10g. Citizen of What Country? 10f, Zip Code 10e. Street and Number 4405 Sycamore Drive 21074 Funeral USA Brightfield Road 21093 death \ Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No 11. Marital Status Black, White, etc. þ 1 Never Married 2 Married 1 Yes If Yes, Give permit. Page 1 and 2 should be filed within 72 hours after to Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or any injury or other traumatic event, the Medical Examin Baltimore, Maryland 21215-0036 white 1 ☐ Yes 2 X No Specify: 3 Widowed 4 X Divorced Completed Year or Dates 16a. Decedent's Usual Occupation 16b. Kind of Business Industry 15 Decedent's Education (Give kind of work done during most of working life, DO NOT use retired) (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) quality control inspector Be 18. Mother's Name (First, Middle, Maiden Surname) 17, Father's Name (First, Middle, Last) Mary Pieszhala ၉ Stephen Stanley Sroka 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code 8523 Freyman Drive Chevy Case, MD 2081519a. Informant's Name/Relationship (Type, Print) Stephen Sroka/brother 20c. Location - City or Town, State 20b. Place of Disposition (Name of 20a. Method of Disposition Date 1 Burial 2 Cremation 3 Removal from State 4
☐ Other (Specify) State Anatomy Board 655 W. Baltimore Street Raltimore,MD 21201 21. Signat Ire of Funeral Service Director Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, or heart failure. List only one cause on each line. Approximate 23a. Part Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Ph_sician/ veor 1VV 1083 Medical Due to (or as a consequence of): **Examiner** patiti Sequentially list conditions, if any, reading to immediate cause. Enter Underlying as a consequence of) Examine Cause (Disease or linjury and that initiated events the burial-trai Due to (or as a consequence of): resulting in death) Last attending physician Physician/Medical Hospital or Attending Physician: The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 use as IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy
5 Other (specify) in the past 12 months?
1 ☐ Yes 2 ☐ No for Pregnant at time of death signed by the aid be detached for 1 Yes 2 L 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e, Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown should been 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed s certificate has blirector, page 2 s 1 Yes 2 No 1 Yes 2 No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) funeral director, Be Other: 4 Nursing Home 5 Residence 6 Tether (Specify Hogpire 2 No ဂ္ 1 Yes 1 Inpatient 2 ER/Outpatient 3 IDOA this 28a. Date of injury (Month, Day, Year) 28c. Injury at work? 28d. Describe how injury occurred 27. Manner of Death 28b. Time of Certificate: After injury 1 Natural 5 Pending 1 Yes 2 No within 24 hours after death.

To the Funeral Director: A completed filled in by the fu Accident Investigation 6 Could not be 3 Suicide 4 Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifier (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated within 2 To the F only one 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number 10070435 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) St snite 4605 21204 Pat chartes 6701 aura Date filed (Month, Day, Year) State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Month 5,20 PM **Physician** Oscar ROL /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) **Examiner** Baltimore Future Care Irvington 9. Birthplace (State or Foreign Country) unk 8. Date of Birth Month, Day, Year) June 26, 1943 If Under 1 Year | If Under 24 Hrs. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** Months Days Hours Min. 1 XM 2 ☐ F Yrs. 265-72-3445 67 Director Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Francisco. 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location 1 Yes 2 □ No Director MD Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21229 USA 22 S. Athol Avenue by Funeral un K2. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status 1 ∐Yes 2 ☐ No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 🂢 No Specify. Specify: black 3 Widowed 4 Divorced Completed 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation unk unk (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) unk unk 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be unk unk ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 22 S. Athol Avenue Baltimore, MD Future Care Irvington 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 📉 Other (Specify) in state 21. Signature of Funeral Service Licensee Ronald Water 22. Name and Address of Facility
State Anatomy Board 655 W. Baltimore Street Director Baltimore, MD 21201 Approximate Interval Between Onset and Death 23a. Pa 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, short or heart failure. List only one cause on each line. Immediate Ca - Final 4 hour **Physician** Multiple organ system disease or condition resulting in death) /Medical Due to (or as a consequence of): **Examiner** inflammator Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that little is devents Due to (or as a consequence of): Examiner this certificate has been signed by the attending physician and ral director, page 2 should be detached for use as the burial-transi piration resulting in death) Last Due o (or as a consequence of Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death in the past 12 months? 3 Ectopic pregnancy Month Day Year 5 Other (specify) 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by 1 Yes 2 No 3 Probably 4 Wunknown prostate cancer matio 24a. Was an autopsy perform 24b. Were autopsy findings available prior to completion of cause of death? marasmu 1 ☐Yes 2 ☐No 1 □ Yes 2 No 25. Was case referred to medical examiner? Be 26. Plac of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To 28a. Date of Injury (Month, Day, Year) 28b. Time of 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No

the Hospital or Attending Physician: The law requires that the death certificate be executed hin 24 hours after death.

the Funeral Director: After this certificate has been signed by the attending physician and the funeral director, completely filled in by

2 Accident 3 🗌 Suicide

29b. Signature and title of certifier

4 Homicide 29a. Certifier (Check only one)

6 □Could not be determined

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

and manner stated.

28f. Location (Street and Number or Rural Route Number, City or Town, State)

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29c. License number

29d. Date signed (Month. Dav. Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

8 800 Boston Highway

Registrar DHMH 17 Rev 1/2001

within 24 hours a To the Funeral L

Medical

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ APRIL 12 2, 2014 7:50 a M CATHERINE PAULINE SPRAYCAR Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner N/A BALTIMORE KESWICK MULTICARE CENTER If Under 1 Year If Under 24 Hrs. Social Security Number 7. Age (In vrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Months Davs Hours Min NOV. 1 Year 917 1 M 2 XF MONTANA **Director** 516-90-5840 93 Usual Residence of Decedent ed other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits within 72 hours after death with the Maryland Director 1X Yes 2 ☐ No N/A BALTIMORE MD 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral U.S.A. 21211 700 W. 40th STREET Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian 11. Marital Status Armed Forces?

1 Yes 2 XNo Black, White, etc. 1 Never Married 2 Married þ Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: If Yes, Give Year or Dates Specify: WHITE Completed 3 X Widowed 4 □ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business Industry Elementary/Seconday (0-12) College (1-4 or 5+) DOMESTIC HOUSEWIFE Be permit. Page 1 and 2 should be filed Department of Health and Mental Hy Important: If item 27 is marked oth any injury or other traumatic event once. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည PIPINICH PAULINE JOHN POMAJEVICH 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 605 WORCESTER ROAD, BALTIMORE, MD 21286 RUDY S. SPRAYCAR/SON 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State cemetery, crematory or other place) 1 Burial 2 X Cremation 3 X Removal from State BAYVIEW CREMATORY 4/13/2011 BALTIMORE, MARYLAND 4 ☐ Donation 5 ☐ Other (Specify) 22 Name and Address of Facilities INC. FUNERAL HOME 1901 EASTERN AVENUE, BALTIMORE, MD 21231 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Betweer On earnd Deut getive Physician/ in disease or condition Medical resulting in death) Due to (or as a consumuence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Physician/Medical Examiner Due to (or as a consequence of) Cause (Disease or linjury that initiated events resulting in death) Last attending physician and Due to (or as a consequence of) The law requires that the death certificate be Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months?
1 Yes 2 No Month Year Pregnant at time of death Day 1 Yes 2 2 9 Unknown been signed by the a should be detached P.0. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Medical Certificate: To Be Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 No has this certificate 1 Yes 2 No Vital or Attending Physician: 25. Was case referred to medical 26. Place of Death (Check only one) 2 No Other: 1 🔲 Yes 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) of 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred : After 1 Matural 5 Pending work? 1 ☐ Yes 2 ☐ No Division ☐ Accident Investigation within 24 hours after deal To the Funeral Director: 3 Suicide 4 Homicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) completed filled in by determined Hospital Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number

DHMH 17 Rev 7/2009

State Registrar

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Charles J. Lolto- Md 21225

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

31. Date filed (Month, Day, Year)

6.20

32. Regis

rar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend #10state of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death asp, Physician/ 14:17 Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death Town, or Location of Death 4b. City, Examiner 14 Medical NA inure LtrnuRe 7. Age (In yrs. last birthday) If Under Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Months Hours Min 03/08/1947 Virginia 1 🛛 M 2 🗆 F 214-44-7711 64 Yrs. Director Usual Residence of Decedent iral", or items 23a or 28a-f shov Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits filed within 72 hours after death with the Maryland Director 1 Yes 2 XNo MD Baltimore Co. Owings Mills 0e Street and Number 10g. Citizen of What Country? 10f. Zip Code Funeral Sherwood Hill Rd. 21117 U.S.A. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14 Bace - American Indian. 11. Marital Status Black, White, etc. 1 XYes 2 □ No If Yes, Give Year or Dates. þ 1X Never Married 2 ☐ Married Saltimore, Maryland 21215-0036 permit. Page 1 and 2 should be filed within 72 hours aft Department of Health and Mental Hyglene. Important: If item 27 is marked other than "natural", any injury or other traumatic event, the Medical Exan once. 1 Yes 2 No Specify: Specify: Black 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4 or 5+) Elementary/Seconday (0-12) Equal Opportunity Rep. 6 years Federal Government Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) 2 Herman Smith Amelia Lee 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) April Smith(niece) 1006 Whatcoat St., Baltimore, MD <u>21217</u> 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place) 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State On-site Crematory 04/12/11 Baltimore, MD 4 Donation 5 Other (Specify) එර්පීම්ව්ර්ෆ්ස් f Brown Jr. Funeral Home PA 2140 N. Fulton Ave., Baltimore,MD 21217 21. Si ture of Funeral Service Licensee 23a rart 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or reart failure. List only one cause on each line. Approximate Interval Between Onset and Death Pnysician/ EREBROVASCULAR ACCIDENT disease or condition Medical resulting in death) Due to (or as a consequence of) **Examiner** Sequentially list conditions Examine Due to (or as a consequence of) if any, leading to immediate attending physician and I for use as the burial-transit Cause (Disease or linjury that initiated events Due to (or as a consequence of) resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 3 Ectopic pregnancy
4 Pregnant at time of death 5 Other (specify)
9 Unknown 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months? Day Month Year Yes 2 No g Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ , MRSA PNEUMONIA 1 ☐ Yes 2 ☐ No 3 X Probably 4 ☐ Unknown Completed completed filled in by the funeral director, page 2 should 24b. Were autopsy findings available prior to completion of cause of death? EFT - VENTRICULAR TUROMBUS 24a. Was an autopsy within 24 hours after death.

To the Funeral Director: After this certificate 2 No 1 Yes 2 1 Yes To the Hospital or Attending Physician; 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner?
1 Yes 2 You Other: 4 Nursing Home 5 Residence 6 Other (Specify) Inpatient 2 - ER/Outpatient 3 - DOA ည Date of injury (Month, Day, Year) 27, Manner of Death 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred Certificate: Natural 5 Pending 1 Yes 2 No Accident Investigation Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 - Homicide determined Medical 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a, Certifier 2 de this place, and due to the cause(s) and manner stated.
3 de Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner stated. only one 29d. Date signed (Month, Day, Year) 29b. Signature and title of ce 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) ORTH GREENC Stepp + Baltimure, M.D. HRISTOPHER KOLTZ 31. Date filed (Month, Day, Year) Registrar's Signa State APR 1 4 2011 Registrar

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Mont Cecilia S. Turney 2011 Medical Apri] 6:40 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Summit Park Nursing Home Catonsville Baltimore Social Security Number 7. Age (In yrs. last birthday If Under 1 Year If Under 24 Hrs Months Days Hours Min. **Funeral** 8. Date of Birth 9. Birthplace (State or Foreign 1 □ M 2 🂢 F Months $J_{an}^{(Month,Day,Year)}$ 930 Colombia Director 214-38-5936 81 Usual Residence of Decedent ms 23a or 28a-f show must be notified at 10a, State 10b. County 10c. City, Town or Location Director 10d. Inside City Limits 1 Tes 2 X No Maryland Baltimore Catonsville 10e, Street and Number 10g. Citizen of What Country? Funeral 1505 Frederick Road 21228 **USA** or items 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, traumatic event, the Medical Examiner Armed Forces? Black White etc. 3 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1X Yes 2 □ No Specify: Colombian White permit. Page 1 and 2 should be filed within 72 hours afti.
Department of Health and Mental Hyglene.
Important: If item 27 is marked other than "natural",
any injury or other traumatic event; the Medical Exan If Yes Give Specify: 3 Widowed 4 Divorced Completed Year or Dates 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Medical Technician Hospital Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 Isaias Sandoval Anais Rodriguez 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Peter B. Turney, Husband 1505 Frederick Road Catonsville, Maryland 21228 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State Metro Crematory Inc. 4 Donation 5 Other (Specify) 04/14/11 Baltimore, Maryland 21. Signature of Funeral Service Thomas Gregor Cremation Society Of Maryland, Inc. 299 Frederick Road Baltimore, Maryland 21228 23a. Part 1. Enter the disease, or complications that caused the death Do not enter the mod of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Onset and Death Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to mini surate cause. Enter Underlying Cause (Disease or iinjury Due to for se a consequence on Examir or Attending Physician: The law requires that the death certificate be executed and for use as the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of) sate has been signed by the attending physician page 2 should be detached for use as the burial Physician/Medical Division of Vital Records, P.O. Box 68760 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months
1 Yes 2 No Pregnant at time of death 5 Other (specify) Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy this certificate 1 Yes 2 No 1 Yes within 24 hours after death.

To the Funeral Director: After this certific completed filled in by the funeral director, Be 25. Was case referred to medical 26. Place of Death Check only one) examiner?
1 Yes 2 No Hospital Other Certificate; To 1 Inpatient 2 ER/Outpatient 3 DOA 5 Residence 6 Other (Specify 27. Manne of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural iniury 5 Pending 1 Yes 2 No Accident Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number. determined Hospital Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29b. Signature and title of certific 30. Name and add h (Item 23a) (Type, Print ess of p State Registrar

DHMH 17 Rev 7/2009

11-02717 Frank J. Testani Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

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			- For State			ificate of	Death		R	eg. No.		
Ph	ysicia		Decedent's Name (First, Middle,La.	st)					2. Date of Dea Month	Day Ye	ar	3. Time of Death
edical E	xami		Frank Joseph Tes	tani			_		April 9, 20	11		0900 hrs
			4a. Facility Name (if not institution, gi	ve street and number)		41		r Location of D	eath	4c. County	of Death	
			Johns Hopkins Hospital		_		Baltimore					
Fu	neral		5. Social Security Number 6. S	ex 7. Age	(In yrs. las	t birthday)	If Under 1 Year If Under 24Hrs. 8. Date of Birth (MM/DD/YYYY) 9. Birthplace (Si					
Dire	ector		216-03-1454	M 2□F 8	9	Yrs.	Months Da	ys Hours	May 10) , 1 921	Col	untMaryland
			Usual Residence of Decedent									10d. Inside City Limits
	T A	- 1	10a. State 10b. County			own or Location	on					1 Yes 2 No
and	Sa-f sho	ь	MD Baltimor	e	Park	wille				. 0:::	h -1 0	71
Aaryl	28a-1	ect	10e. Street and Number				10f. Zip Code		1	0g. Citizen of W	nat Cour	ntry ?
the	tifie	吉	8820 Walther Blvo	1. #2414			21234			USA		
with N	De D	Funeral Director	11. Marital Status	12. Was Decedent E Armed Forces?	ver in U.S	. 13. Was	Decedent of H	ispanic Origin? an. Mexican, Pu	(Specify Yes or No erto Rican, etc.)		e - Ameri e, etc.	can Indian, Black,
death	or ite	È	1 Never Married 2 Marrie	1X Yes 2	No						, ,	
after	al",	Š		d If Yes, Give Year or Dates:			Yes 2 X N		l ef conde done	Specify: 16b. Kind of B		
hours	Cxam		15. Decedent's Education (Specify of					ation (Give kind e. DO NOT use		TOD. KING OF D	usii less/i	ridustry
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212	marked marked	ToB	19a. Informant's Name/Relationship (Type, Print)	-	19b. Mailing	Address (Stre		or Rural Route Nu	mber, City or To	vn, State	, Zip Code)
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and and	fitem 27		20a. Method of Disposition		20b. Pl		tion (Name of c		Date	20c. Location	- City or	Town, State
MOFE Pages 1	of F	ш	1 Burial 2 Cremation 3		9			mione /	1/13/2011	Timoni	1 1m	MD
Baltimore,	yor	}	4 Donation 5 X Other Specif 21. Signature of Funeral Solvice Light	hsee	рина	22. N	ame and Addre	ss of Facility	+/ 13/ 2011	1 111110113		York Road
Ba perm	Department of H Important: If i		10414	Person .		Ru	ck Tows	on Fune	eral Home	. Inc.		son, MD 2120
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68 certifi	nding Se as	ä	past 12 months?	1 Live birth Pregnant at t	ime of dea		al death 3 ner (S <i>pecify</i>)	Ectopic pr	egilaticy	World		ouy rou
So Y	for u	Physician/I	1 Yes 2 No 9 Unknow	yn 9 Unknown		3 <u></u>	iei (opcon))					
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Hosp	24 ho Fune stely f		29a. Certifier 1 Certifying Physic	cian: To the best of my	knowledg	e, death occur	red at the time,	date and place	, and due to the cau	use(s) and mann	er as stat	ted.
Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be executed	within 24 hours after death. To the Funeral Director: After t completely filled in by the funeral	Medical		er:On the basis of exam and manner stated.	nnation ar	nd/or investigat			red at the time, date		_	
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D 93		e le	Name and address of person who Donna M. Vincenti, MD Date filed (Month, Day, Year)	Assistant Medic	al Exam	iner 111	Penn Stree	et, Baltimore	e, MD 21201			

DHMH 17 Rev 1/2001 OCME 2006

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygienes State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ March 25, 2011^{ear} Parthanne Deresa 7:54 A hompson Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Shady Grove Adventist Hospital Rockville Montgomery Social Security Number Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 🗆 M 2 😿 F Months Days Hours Min September 30, 1927 Florida **Director** 263-36-5470 Usual Residence of Decedent Show if of Health and Mental Hygiene.
If item 27 is marked other than "natural", or items 23a or 28a-f sho or other traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location with the Maryland Director 10d. Inside City Limits 1 X Yes 2 No Maryland | Frederick Frederick 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 1004 Snowberry Way 21703 United States 72 hours after death Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian, Armed Forces?
1 ☐ Yes 2 🕱 No Black, White, etc. Completed by 1 Never Married 2 Married Maryland 21215-0036 If Yes, Give 1 Yes 2 X No Specify: Specify: Black 3 ₩ Widowed 4 Divorced Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4 or 5+) Elementary/Seconday (0-12) Own Home Homemaker Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 Hezekiah Fountain Annie Johnson 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) . Page 1 and 2 sl trnent of Health a tant: If item 27 is William J. Thompson, Jr./Son 1004 Snowberry Way, Frederick, Maryland 21703 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of April 15 2011 20c. Location - City or Town, State cemetery, crematory or other place)
Montgomery
Crematorium, Inc. 1 🗆 Burial 2 😾 Cremation 3 🗆 Removal from State 4 Donation 5 Other (Specify) Bethesda, Maryland 22. Name and Address of Facility Robert A. Pumphrey Funeral Home/Rockville; Inc. 130 West Montgomery Avenue 21. Signature of Funeral Service Licenses M01498 ROCKVIIIe; Inc. 120 W6550 FIOT Approximate Interval Between shock, or heart failure. List only one cause on each line Immediate Cause (Final Onset and Death Physician/ Myocardial Infarction disease or condition resulting in death) hour Medical Due to (or as a consequence of) Examiner oronary Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Examiner Due to (or as a consequence of) the Hospital or Attending Physician: The law requires that the death certificate be executed signed by the attending physician and d be detached for use as the bunal-transit pertension ears that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Diabetes ears Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregna 5 Other (specify) Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No
9 ☐ Unknown Pregnam
Unknown Pregnant at time of death Month Day Year Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 1 No 3 ☐ Probably 4 ☐ Unknown peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an After this certificate has funeral director, page 2 s autopsy performed 1 ☐ Yes 2 ☐ No Yes 2 N 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No မှ 1 Tes 1 ☐ Inpatient 2 → ER/Outpatient 3 ☐ DOA 28a. Date of injury (Month, Day, Year) Manner of Death 28b. Time of Certificate: 28c. Injury at 1 Natural 5 Pending work? 1 ☐ Yes 2 ☐ No Accident Investigation 3 ☐ Suicide 4 ☐ Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 🗜 🚾 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated within 2 To the F Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D0064235 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 9 V Of Dr Rockville MD 20150 9901 MD Medical 31. Date filed (Month, Day, Year) State Registrar

DHMH 17 Rev 7/2009

0750

3/25/

Thompson

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ JESSE LEE WATSON, III APR 8 2011 10:05 Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death NATIONAL NAVAL MEDICAL CENTER **BETHESDA** MONTGOMERY 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 8. Date of Birth Nov. 8, 1946 9. Birthplace (State or Foreign Country) Texas 7. Age (In yrs. last birthday) Funeral Days Hours 1 🗶 M 2 🗆 F Months 451-86-5694 Yrs Director 64 Usual Residence of Decedent show 10b. County with the Maryland Examiner must be notified at 10a. State 10c. City, Town or Location 10d. Inside City Limits Director 28a-f Virginia 1 ☐ Yes 2 X No Fairfax Centreville 10e. Street and Number ō 10f. Zip Code 10g. Citizen of What Country? Funeral items 23a 14606 Mt. Olive Road 20121 U.S.A. 72 hours after death 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Forces?

1 X Yes 2 No 1970 Black, White, etc. "natural", or 1 Never Married 2 Married δ Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 🛛 No Specify: 3 Widowed 4 Divorced Specify: Completed 1993 Black event, the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) and Mental Hygiene. School Principle Public Schools Be Page 1 and 2 should be filed ment of Health and Mental Hy 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Malden Surname) ပ Watson Ruth Currie 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Faye Watson (Spouse) 14606 Mt. Olive Rd., Centreville, VA 20121 permit. Page 1 and 2 Department of Health Important: If item 27 any injury or other tr 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other p 20c. Location - City or Town, State 1 X Burial 2 Cremation 3 Removal from State Fairfax Memorial Park 4/14/2011 Fairfax, VA 4 Donation 5 Other (Specify) Sign flure of Fu 23. Name and Address of Facility P.O. Box 3633, Home, Inc. Warrenton, VA 20188 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Ph sician/ LEUKEMIA disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of): Cause (Disease or linjury that initiated events resulting in do-" or Attending Physician: The law requires that the death certificate be executed and the burial-tran Due to (or as a consequence of): attending physician Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No Day Year 5 Other (specify) Pregnant at time of death
Unknown been signed by the a should be detached f 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? δ Completed 1 Yes 2 No 3 Probably 4 Unknown Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy within 24 hours after death.

To the Funeral Director; After this certificate I completed filled in by the funeral director, page 2 🔯 No 1 ☐ Yes 2 ☐ No Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) 2 2 🛛 No Other: 1 Yes 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 X Natural 5 Pending injury 1 ☐ Yes 2 ☐ No ☐ Accident☐ Suicide Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Medical 1 X Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check 3 Certifying-Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) ROLI 01055104A (IN)

ÐHMH 17 Rev 7/2009

State Registrar NATIONAL NAVAL MEDICAL CENTER

BETHESDA MD 20889-5600

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

LCDR

32. Registrar's Sign

MC

USN

MICHAEL BAYDARLAN

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygienery Certificate of Death Reg. No. 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Day April 2011ª 9:00 Ам 11 PATRICIA ANN WISE 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Wicomico Pittsville 35070 Sunrise Court Birthplace (State or Foreign Country) If Under 1 Year | If Under 24 Hrs. 7. Age (In yrs. last birthday) Date of Birth (Month, Day, Days Hours Min. 1 □ M 2 🕅 F 65 212-42-9035 Jan. 2,1946 Maryland Usual Residence of Decedent 10d. Inside City Limits 10a State 10h. County 10c. City, Town or Location 1 ☐ Yes 2 X No Pittsville Wicomico Maryland 10g. Citizen of What Country? 10f. Zip Code 10e Street and Number USA 21850 35070 Sunrise Court 14. Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 11 Marital Status 1 ∐Yes 2 X No If Yes, Give Year or Dates: 1 Never Married 2 Married Specify: White 1 □Yes 2 No Specify: 3 X Widowed 4 ☐ Divorced 16b. Kind of Business/Industry 16a Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Food Service Worker Food Industry 12 yrs. N/A 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Margaret E. Taylor Lewis Conner 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 4004 Glenmore Avenue Baltimore, Md. 21206 Nancy L. Wrobel (Sister) 20b. Place of Disposition (Name of cametery, crematory or other place)
HOLLY HILL M. G. Date 20c. Location - City or Town, State 20a. Method of Disposition 1 N Burial 2 ☐ Cremation 3 ☐ Removal from State 4-15-2011 Baltimore, Md. 4 □ Donation 5 □ Other (Specify) 22. Name and Address of Facility Lassahn Funeral Home 21. Signal re of Funeral Service Licensee Lassahn Funerai nome 7401 Belair Rd. Baltimore, Md. 23a. Part 1. Enter the disease, or complications that caused the death: Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Wetcetatic Corcinoma The & rucet year 4 mortes Immediate Cause (Final disease or condition resulting in death) Due to (or as a consequence of) Sequentially list conditions, if any, leading to infine date cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for se's consequence of Due to (or as a consequence of) IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day Year in the past 12 months?

1 Yes 2 No 4 Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an performe 1 ☐Yes 2 ☐No 1 □Yes 2 No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1∐ Yes 2. No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred

Physician /Medical Examiner Examine and

Physician

/Medical

Examiner

Director

Funeral

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Be Completed

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Funeral

Director

filed within 72 hours after death with the Maryland

3altimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Evantines must be notified at

burial-transit attending physician for use as the burial Medical I the this certificate

Hospital or Attending Physician: The law requires that the death certificate be executed Division of Vital Records, P.O. Box 68760, hours after deatl uneral Director; within 24 hours a

To the Funeral C

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led in by the funeral director, page 2 snould be detached for use	Cortification: To Be Completed by Dhysician/
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5 Pending investigation 1 Natural 2 Accident 6 ☐ Could not be 3 Suicide 4 ☐ Homicide

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

1 ☐ Yes 2 ☐ No

28f. Location (Street and Number or Rural Route Number, City or Town, State) 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29b. Signature and title of certifier Form " 1.

29c. License number D00143 14 29d. Date signed (Month, Day, Year) 4/11/2011

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

ANPT P. KUG, 100 East Caucil 27ml, Solisbury 'Md. 21801

Registrar

Medical

31. Date filed (Month, Day, Year) APR 1 4 2011

29a. Certifier

(Check only one)

and manner stated.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend #19a Per FH G914 4/14/2011 JH State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. nt's Name (First, Middle, Last) 2. Date of Death 3. Time of Death 10:25PM Physician/ Hori " 201 ton Medical 4b. City, Town, or Location of Death Name (if not institution, give street and number) 4c. County of Death Examiner Himore If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign Funeral 7. Age (In vrs. last birthday) Months Hours Min. 1 □ M 2 🕶 F 212-26-3125 Director 10b. County Town or Location 10a. State 10c. City. 10d. Inside City Limits filed within 72 hours after death with the Maryland items 23a or 28a-f sho her must be notified at Director 1 🗆 Yes 2 🔀 No Baltimore 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral USA Wenue 2120 west 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married o. Completed by Yes Yes, Give Baltimore, Maryland 21215-0036 1 Yes 2 No Specify 3 Divorced "natural" Year or Dates the Medical 15. Decedent's Education 16a, Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working iffe. DO NOT use retired) (Specify only highest grade completed) Page 1 and 2 should be filed within 72 nent of Health and Mental Hygiene. ant: If item 27 is marked other than ' College (1-4 or 5+) conday (0-12) omestic Important: If item 27 is marked other any injury or other traumatic event, Be rls Name (First, Middle မ Zip Code) 21207 Leonard Name/Relationship (Type, or Rural Route Number 19b. Mailing Address (Street and Number Washington (Husband) 1426 torest 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory of other place) Location - City or Town, State permit. Page 1 a Department of I ■ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 Donation 5 Other (Specify) 21. Signature of Fundral Service License 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or hear railure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final tai ₹πysiciaπ/ disease or condition resulting in death) Medical Due to (o a eensequence of Examiner Sequentially list conditions, it cause. Enter Underlying Cause (Disease or iinjury Examiner Due to for as a consequence of Hospital or Attending Physician: The law requires that the death certificate be executed and use as the burial-trar that initiated events resulting in death) Last Due to (or as a consequence of): s been signed by the attending physician should be detached for use عد الماه كالماه Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No Month Day Veal Pregnant at time of death 5 Other (specify) Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 3 Probably 4 Lighknown 2 🗌 No certificate has been 24b. Were autopsy findings available prior to completion of cause of 24a. Was an page 2 autopsy performed death? 1 Yes 2 No Yes 2 25. Was case referred to medical examiner? funeral director, 26. Place of Death (Check only one) Be Hospital မ 1 Yes 2 L M 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify) After this 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: 1 Natural 5 Pending injury work? 1 ☐ Yes 2 ☐ No Accident Investigation 24 hours after deat Funeral Director: Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, filled in by 4 Homicide determined City or Town, State) Medical 29a. Certifie Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. completed (Check within 2 To the I only one) 29b. Signature and title of 29c. License number 29d. Date signed (Month, Day, Year) D007007 who completed cause of death (Item 23a) (Type, Print) 30. Name and address of person Partuille, mp-21234 20L State Registrar

1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day Yea **Physician** PM2, 2011 George Wienecke April /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death Examiner Seasons Hospice @ NW Hospital Randallstown Baltimore If Under 1 Year | If Under 24 Hrs.

Months Days Hours Min. 8. Date of Birth (Month, Day, Apr 1, 9. Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Days unk 1 X M 2 □ F 577-07-4152 95 Director Usual Residence of Decedent 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any hjury or other traumatic event, Ite Medical Examiner must be redifficed at once. 1 ☐ Yes 2√☐ No Director MD Baltimore Baltimore 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number USA 21207 4813 Gwynn Oak Avenue Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No U If Yes, Give Ye ar or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 X Never Married 2 ☐ Married unk Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify. white Specify: þ 3 Widowed 4 Divorced Completed 16b. Kind of Business/Industry unk 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) College (1-4or 5+) Elementary/Secondary (0-12) electrician 18. Mother's Name (First, Middle, Maiden Surname) unk 17. Father's Name (First, Middle, Last) Be မ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 201 E. Baltimore Street Baltimore, MD Pamela Klecan/guardian 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 22. Name and Address of Facility Phillip A Weathefford Fit Phillip A W 1 Burial 2 ☐ Cremation 3 ☐ Removal from State Garrison Forest Vet Cem 4 ☐ Donation 5 ☐ Other (Specify) ice Licensee 21. Signature of Funeral Servine Ronal G Street 23a. Party. Enter the risease, or or implications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shocker heart failure. List only one cause on each line. Immediate Cause (Final Multiple **Physician** Extrem: disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine To the Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of): P.O. Box 68760, Physician/Medical IF FEMALE: yes, outcome of pregnancy □ Live birth 2 □ Fetal death □ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 🗆 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Ye ar 5 ☐ Other (specify) 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 □Yes 2 ■No 24a. Was an autopsy perform 2**V** No 1 ☐ Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DDA Other: 4 Nursing Home 5 Residence 6 Other (Specify) Medical Certification: To After this 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending 1 □Yes 2 No within 24 hours after death.

To the Funeral Director: A completely filled in by the fu 2 Accident March 9,28\\ unknown 1 L

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) investigation ta. 6 ☐ Could not be 3 Suicide 28f. Location (Street and Number of Rural Route Number Ave City or Town, State) 43,367nne Oak Ave Baltimore, Maryland 21207 determined 4 Homicide Nusing Home 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one)

Please Type or Print in Black Indelible Ink, Ensure All Copies Are Legible.
AMEND TIEM# 20a-c, 22 per FH, G915, 5/13 / 2011, ws State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No...

29d. Date signed (Month, Day, Year)

Registrar DHMH 17 Rev 1/2001

State

29b. Signature and title of certifier

30. Name and address of person

31. Date filed (Month,

who completed cause of death (Item 23a) (Type, Print)

29c. License number

Trimble Hill CT. Lutherville, Maryland 21093

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene for State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death April Physician/ 20°1'1 4:10 Helen L. Ward A M Medical 4a. Facility Name (if not institution, give street and number, 4b. City, Town, or Location of Death 4c. County of Death Examiner Montgomery 9416 Tobin Circle Potomac . Social Security Numbe 7. Age (In vrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Months Hours Min (Month Day, Year) av 23, 1919 1 🗆 M 2 💢 F North Carolina 577-07-6887 Director 91 May Usual Residence of Decedent 28a-f show 10a. State 10b. County 10d. Inside City Limits at 10c. City. Town or Location with the Maryland Director notified 1 Yes 2 X No Maryland Montgomery Potomac 10e. Street and Number 10f. Zip Code ò 10g. Citizen of What Country? Examiner must be 23a Funeral 20854 United States 9416 Tobin Circle items 2 within 72 hours after death Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian. Armed Forces?

1 Yes 2 X No Black, White, etc. ō 1 Never Married 2 Married ò Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 Yes 2 No Specify: Specify: White Page 1 and 2 should be filed within 72 hours aft ment of Health and Mental Hygiene. ant: If item 27 is marked other than "natural", Completed 3 X Widowed 4 Divorced the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) 12 College (1-4 or 5+) Collection Manager Banking Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Carland Elsie. Walter Yarborough 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 sh Department of Health ar Important: If item 27 is any injury or other trau once. 9416 Tobin Circle, Potomac, Maryland 20854 Shirley W. Watkins / Daughter April 16, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Darnestown Presbyterian Church Cemetery 1 X Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) Gaithersburg, Maryland 21. Signature of Fundral Service Licenses Robert A. Pumphrey Funeral Home/Rockville, Inc. marketter demin M01305 300 West Montgomery Avenue, Rockville, Maryland 20814-3501 23a. Part I Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, should, or heart failure. List only one cause on each line. Approximate Interval Betweer Immediate Cause (Final Months

Onset and Death Ph, sician/ Malignant Neoplasm of the Brain disease or condition Medical resulting in death) Due to (or as a consequence of Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of) Cause (Disease or iinjury The law requires that the death certificate be executed burial-transi that initiated events resulting in death) Last and Due to (or as a consequence of) ending physician are use as the burial-Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death use 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) in the past 12 months?
1 ☐ Yes 2 X No for Year Day Pregnant at time of death Month signed by the at d be detached for g Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 X Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an page 2 s autopsy performed? Yes 2 K No certificate Hospital or Attending Physician: 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 X Residence 6 Other (Specify) Hospital 1 Yes _2 💢 No ပ္ 1 Inpatient 2 ER/Outpatient 3 DOA this funeral 28a. Date of injury (Month, Day, Year) Manner of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 X Natural 5 Pending work? 1 ☐ Yes 2 ☐ No 24 hours after death Funeral Director: A ☐ Accident ☐ Suicide Investigation filled in by the 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Medical 29a. Certifier X Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. pleted Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 3 within 2 only one) 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month. Day, Year) D37142 12-2011

State Registrar 1355 Piccard Drive, Suite 100, Rockville, Maryland 20850

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

2011

Geoffrey Coleman, MD

31. Date filed (Month

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene, State Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death 8 15 PM Month Physician/ Z O J helma Medical 4a. Facility Name (if not institution, give street and number) City, Town, or Location of Death **Examiner** 4c. County of Death N/A BALTIMORE ESTHER'S PLACE 5. Social Security Number 6. Sex If Under 1 Year | If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign 7. Age (In vrs. last birthday) **Funeral** MAY 15 Year 931 1 □ M 2 🗶 F Months Days Hours KENTUCKY 230-32-8104 Yrs. Director 79 Usual Residence of Decedent 10d. Inside City Limits items 23a or 28a-f shov 10a. State 10b. County 10c. City, Town or Location filed within 72 hours after death with the Maryland Examiner must be notified at Director 1 Yes 2 No BALTIMORE N/A MD 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral U.S.A. APT. 21231 1627 EASTERN AVENUE 410 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, 11. Marital Status Armed Force Black, White, etc. ō 1 Never Married 2 Married Yes 2X No Completed by Saltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 ☐ No Specify. WHITE Specify: "natural", 3 XWidowed 4 Divorced the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working al Hygiene. life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) RETAIL SALES 10 traumatic event, Be permit. Page 1 and 2 should be filed. Department of Health and Mental Important: If item 27 is many injury or other. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည CECIL KENNEDY LEONA CHARLIE DALE 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 5503 WATERS EDGE DRIVE, MINERAL, VA 23117 BILLY DALE/ BROTHER 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) cemetery, crematory or other place) BAYVIEW CREMATORY 4/11/11 BALTIMORE, MARYLAND 21. Signature of Funeral S Name and Address of Facility LER INC. FUNERAL HOME AVENUE, BALTIMORE, MD 21231 EASTERN 901 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Betweer Onset and Death Chronic Immediate Cause (Final Physician/ TUC voca. disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions Examine Due to (or as a consequence of) if any, leading to immediate cause. Enter Underlying attending physician and for use as the burial-transit or Attending Physician: The law requires that the death certificate be executed Cause (Disease or linjury that initiated events Due to (or as a consequence of) resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months? Month Day Year the page 2 should be detached Unknown 9 Unknown been signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? à 1 Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an onaestive certificate has autopsy performed 1 Yes 2 No Yes 2 25. Was case referred to medical funeral director, l e 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 1 🗌 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA မ Director: After this 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 1 Natural 28b. Time of 28c. Injury at 28d. Describe how injury occurred injury 5 Pending 1 Yes 2 No ☐ Accident Investigation filled in by the 3 Suicide
4 Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined within 24 hours a To the Funeral D Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier сотріете Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practioner. To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one 29b. Signature and title of certi-29d Date signed (Month, Day, Year) 201

State Registrar 30. Name and address

31. Date filed (Month, Day, Year)

940 Eastern Ave

of person who completed cause of death (Item 23a) (Type, Print)

32. Re

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene-1 - For State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) A Pri L 4:00 P M Physician/ 101 Okin Medical 4c. County of Death 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** MONTGOMERY MONTGOMERY HOSPITAL 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign Social Security Number **Funeral** 220-08-283 1 🗆 M 2 🗶 F Months Hours Grea **Director** 10d. Inside City Limits 28a-f shov permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-1 show any injury or other traumatic event, the Medical Examiner must be notified at 10b. County 10c. City, Town or Location 10a. State Director 1 Yes 2 No ROCKVIIIS MONTGOMER 10g. Citizen of What Country? 10e. Street and Number Bauer 20853 Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12, Was Decedent Ever in U.S. 11. Marital Status Armed Forces?...
1 Yes 2 No Black, White, etc. 1 Never Married 2 Married Completed by Asian Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: If Yes, Give Year or Dates 3 ₩ Widowed 4 □ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry 15. Decedent's Education (Specify only highest grade completed) OMOSTIC College (1-4 or 5+) Elementary/Seconday (0-12) Housewite Be 18. Mother's Name (First, Middle, Malden Surname) Father's Name (First, Middle, Last) မ SUNG ONG 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Road Mill SON 20c. Location - City or Town, State 20b. Place of Disposition (Name of 20a. Method of Disposition cemetery, crematory or other place 1 N Burial 2 Cremation 3 Removal from State 12-2011 Olney 4 ☐ Donation 5 ☐ Other (Specify) HOWEL Signature of Funeral Service License 22. Name and Address of Facility 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Phylician/ Cardiovascular Athereonlewis icar) disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Abdomina JEDIV.) Sequentially list conditions, it any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence on) attending physician and for use as the burial-transit Cause (Disease or linjury that initiated events resulting in death) Last To the Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant Ectopic pregnancy in the past 12 months? Year Month Day Other (specify) Pregnant at time of death i signed by the a Id be detached f g Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 1 🗌 Yes Completed peen s 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performed 1 ☐ Yes 2 ☐ No ieral Director: After this certificate I filled in by the funeral director, pag 1 ☐ Yes 2 € 25. Was case referred to medical 26. Place of Death (Check only one) Certificate: To Be examine? 2 🗆 No 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28c. Injury at work? 1 ☐ Yes 2 ☐ No 27. Manne of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred 5 Pending Investigation 1 Natural hours after death. ☐ Accident ☐ Suicide Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined within 24 hours a To the Funeral C Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one 29b. Signature and title of certif 29d. Date signed (Month, Day, Year) 9, 2011 DO0 33414 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 31. Date filed (Month, Day, Year)
APR 1 4 2011 10181 32. Registrar's Sinature State Registrar

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1, Decedent's Name (First, Middle, Last) 2. Date of Death Alonth Alonth Day **Physician** Milan Zeruto 22 PriL 2011 /Medical 4a. Facility Name (If not institution, give street and number) Care 4b. City, Town, or Location of Death 4c. County of Death Examiner Assisted Living Well Compassionate Millersville Anne Arundel If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) 11/19/1924 Birthplace (State or Foreign Country) **Funeral** Min. 1 □ M 2 🕅 F Months Days Hours 215-74-6786 86 Director Puerto Rico Usual Residence of Decedent filed within 72 hours after death with the Maryland 10a, State 10c. City, Town or Location 10d. Inside City Limits ral", or items 23a or 28a-f show Express must be notified at Director 1 ☐ Yes 2 ☐ No MD Millersville Anne Arundel 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Aurora Drive 21108 Completed by Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, 11 Marital Status Black, White, etc. 1 ☐ Yes 2√∑ No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married Puerto Baltimore, Maryland 21215-0036 than "natural", or 1 XYes 2 □ No Specify: Specify. 3₺ Widowed 4 Divorced Rican Hispanic the Mudical Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: If item 27 is marked other than any Injury or other traumatic event, the M 12 Own Home Homemaker 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Jose Rivera ပ Juana Lopez 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 189 Pasadena, Maryland 21122 Mr. Jose Zeruto / son 12th Street, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☑Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) MD Veterans Cemetery 4/18/2011 Crownsville, MD 21. Signature of Funeral Service Licenses 22. Name and Address of Facility 1 2nd Ave, SW Glen Burnie, MD 40357 Singleton Funeral & Cremation Services, P.A. 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician ongestine Heart /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Litter drivering Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of): Hospital or Attending Physician: The law requires that the death certificate be executed and Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, signed by the attending physician Completed by Physician/Medical as IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 9 ☐ Unknown 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown 23d. Date of delivery 3 Ectopic pregnancy Month Day Year 5 Other (specify) detached Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 No 3 Probably 4 Unknown After this certificate has been 24b. Were autopsy findings available prior to completion of cause of death? 1 □Yes 2 □No 24a. Was an autopsy perform 1 ☐ Yes 2 No 25. Was case referred to medical examiner? Be 26. Place of Death (Check onl one) 6 Other (Specify) L. U. J. Hospital: 1 Yes 2 No Other: 4 Nursing Home 5 Residence ပ 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of Injury (Month, Day, Year) 28d. Describe how injury occurred Certification: 27. Manner of Death 28b. Time of 28c. Injury at Work? 1 Natural 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No after death. 2 Accident filled in by the 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide within 24 hours a

State Registrar

Medical

29a. Certifier

(Check only one)

mohi

APR 1 4 2011

29b. Signature and title of certifier

31. Date filed (Month, Day, Year)

Neg

and manner stated.

m.J 30. Name and address of solution who completed cause of death (Item 23a) (Type, Print)

601

32. Registrar's Signature

Velerans

back

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29c. License number

Mulercyille.

29d. Date signed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State
Registrar Amend#6 perFH, FCHD, 4/8/11, LECertificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Physician/ 201^{Yea} 9:15a M March David C. Anderson Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Frederick Kline Hospice House Mt. Airy Social Security Number If Under 1 Year If Under 8. Date of Birth 9. Birthplace (State or Foreign 7. Age (In vrs. last birthday) **Funeral** 1 X M 2 131 Months Hours Min (Month, Day, Ye Washington D.C. 52 1958 Director 216-72-0643 Dec. Usual Residence of Decedent or 28a-f show 10d. Inside City Limits permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Heatth and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show 10b. County ed other than "natural", or items 23a or 28a-f sho event, the Medical Examiner must be notified at 10a. State 10c. City. Town or Location Director 1 Yes 2 X No Mt. Airy Marvland Frederick 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 12932B Jesse Smith Road 21771 United States 12. Was Decedent Ever in U.S. Armed Forces?
1 ☐ Yes 2 ☒ No If Yes, Give 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. Completed by 1 Never Married 2 X Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify: 3 Widowed 4 Divorced White Year or Dates 15 Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done of life. DO NOT use retired) during most of working Elementary/Seconday (0-12) College (1-4 or 5+) Automotive Auto Technician Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည John Anderson Louise Nickerson other traumatic 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mary J. Anderson/ Wife Airy, Maryland21702 12932 B Jesse Smith Road, Mt. 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State cemetery, crematory or other place) 1 Durial 2 X Cremation 3 Removal from State injury or 4 ☐ Donation 5 ☐ Other (Specify) Stauffer Crematory Inc. 3/29/2011 Frederick, Maryland. 22. Name and Address of Facility Stauffer Funeral 1621 Opossumtown Homes P. A. Pike, Frederick, Maryland 21702 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only due cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ Due to (or s a consequince of): atera disease or condition Medical resulting in death) Examiner Sequentially list conditions, Examiner Due to (or as a consequence of): cause. Enter Underlying Cause (Disease or linjury executed as the burial-transi and that initiated events Due to (or as a consequence of): resulting in death) Last by the attending physician Physician/Medical Hospital or Attending Physician: The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Year Month Day Pregnant at time of death 5 Other (specify) should be detached 1 ☐ Yes ∠ □ g ☐ Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? signed I þ 2 No 1 🗌 Yes 3 ☐ Probably 4 ☐ Unknown Completed peen s Were autopsy findings available prior to completion of cause of death? 24a. Was an has performed this certificate 1 ☐ Yes 2 ☐ No iours after death.

Neral Director: After this certifical in by the funeral director. To Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 1 Tes 4 Nursing Home 5 Residence 6 Other (Specify) Hospice 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of De 28c. Injury at work? 28a. Date of injury (Month, Day, Year) 28b. Time of 28d. Describe how Injury occurred Certificate: 1 Natural 5 Pending 1 Yes 2 No Accident Investigation Suicide Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide To the Hospital within 24 hours a To the Funeral C Medical 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 2/6

DHMH 17 Rev 7/2009

State Registrar 31. Date filed (Month, Day,

Registrar's Signature

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36	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important; If item 27 is marked other than "natural", or items 23a or 28a-f show any hiury or other traumatic event, the Medical Examiner must be notified at once.	þ	11. Marital Status 1 ☐ Never Mari 3 ☐ Widowed		ried 1	is Decedent ned Forces? Yes 2 — 'es, Give		rea		ify Cuba	n, Mexica	n, Puerto f	cify Yes or No- Rican, etc.)			, White,	can Indian, etc. nite
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Division of Vital Records, P.O. Box 68760

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Amend#19aperFH, FCHD, 3/30/11, Lettificate of Death Registrar 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Physician/ \mathbb{A}^{M} 4:41 COLLEEN LYNN GOOD BEAR March 2011 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Frederick Frederick Frederick Memorial Hospital If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign 8. Date of Birth Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** 1 🗆 M 2 🏝 Days Hours Min. Oct. 6, 1947 Minnesota Director 538-48-2458 63 Usual Residence of Decedent or 28a-f shov 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits th and Mental Hygiene. 27 is marked other than "natural", or items 23a or 28a-f sho traumatic event, the Medical Examiner must be notified at Director 1 ☐ Yes 2X No Maryland Frederick Frederick 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number Funeral be filed within 72 hours after death with 21704 United States 2802 Thurston Road Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. 11. Marital Status Armed Forces? Black, White, etc 1 Never Married 2 Married <u>Ş</u> Maryland 21215-0036 American 1 Yes 2 K No Specify: Specify: If Yes, Give 3 - Widowed 4 K Divorced Completed Indian Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15 Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) 5+ U.S. Government Social Worker Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) ဂ permit. Page 1 and 2 should be Department of Health and Men Important; If item 27 is marke any injury or other traumatic. once. Irene Frederick Joseph Langer 19a. Informant's Name/Relationship (Type, Print)
Danielle Steward
Danielle Frederick / Daughter 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Frederick, Maryland 21704 2802 Thurston Road Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State cemetery, crematory or other place) 1 Burial 2 X Cremation 3 Removal from State arch 2011 4 ☐ Donation 5 ☐ Other (Specify) Frederick, Maryland Frederick Crematory S ature of uperal Service License 22. Name and Address of Facility Stauffer Funeral Homes, P.A. 1621 Opossumtown Pike Frederick, Maryland 21702 Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition Medical resulting in death) Due to (or as a consequen Examiner rein Sequentially list conditions, Due to (or as a consequence of) Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury the attending physician and hed for use as the burial-transit that initiated events Due to (or as a consequence of) resulting in death) Last Physician/Medical or Attending Physician; The law requires that the death certificate be P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
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neral Director; After the filled in by the funeral eath 28a. Date of injury 28c. Injury at work? 28d. Describe how injury occurred Certificate: (Month, Day, Year) Matural 5 Pending injury 1 Yes 2 No M Accident Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) To the Hospital within 24 hours a To the Funeral D Medical Ceptifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Certifying Nurse Practioner. To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one)

Registrar

State

29b. Signature and

30. Name and address of pers

who completed cause of death (Item 23a) (Type, Print) INDV

Registrar's Signature

HUMPA

32

29c. License number

MDD

29d. Date signed (Month, Dav. Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygienes Certificate of Death Registrar 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 23^y 20 l°1 Patricia A. Bodmer March 7:15p M Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Frederick 8819 A. Rocky Ridge Road Thurmont 8. Date of Birth

8. Date of Birth

9. Birthplace (State S.)

Country)

Jan. 14, 1959 Washington D. C 5. Social Security Number If Under 1 Year If Under 24 Hrs Age (In yrs. last birthday) **Funeral** Days 1 □ M 2 🕱 F Months Hours Min Director 215-80-2702 52 Usual Residence of Decedent 2 should be filed within 72 hours after death with the Maryland thit and Mental Hygiene. 27 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Examiner must be notified at 10b. County 10a. State 10c. City, Town or Location 10d. Inside City Limits Director 1 ☐ Yes 2 🏝 No Maryland Frederick Thurmont 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? Funeral 8819 A. Rocky Ridge Road 21788 United States 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian Armed Forces?
1 ☐ Yes 2 🔀 No Black, White, etc. 1 Never Married 2 X Married þ Baltimore, Maryland 21215-0036 Specify: White 1 Yes 2 No Specify: If Yes Give 3 Widowed 4 Divorced Completed Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) 4 Homemaker Own Home Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 Virginia Billey John Downs I and 2 should b I Health and Mei Item 27 is mark 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 s
Department of Health
Important: If item 27
any injury or other tra 8819 A. Rocky Ridge Road, Thurmont, MD 21788 Robert B. Bodmer/ Husband 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 Durial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Stauffer Crematory Inc. 3/28/2011 Frederick, Maryland. 21. Signature of Moneral Service Lit Stauffer Funeral Homes P. A. 1621 Opossumtown Pike, Frederick, MD Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition Physician. neumon la Medical resulting in death) Due to (or as a consequence of). Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of): Cause (Disease or iinjury that initiated events resulting in death) Last To the Hospital or Attending Physician; The law requires that the death certificate be executed attending physician and for use as the burial-tran Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: nse 23b. Was decedent pregnant 23d. Date of delivery Live Birth 2 Fetal death
Pregnant at time of death 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months? Month Day Year 9 Unknown been signed by should be detac Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ۾ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performed? within 24 hours after death.

To the Funeral Director: After this certificate I completed filled in by the funeral director, page 1 Yes 2 No 25. Was case referred to medical 26. Place of Death (Check only one) B B examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) ၉ 2 - No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Death 28h Time of Certificate: 28a Date of injury 28c. Injury at 28d. Describe how injury occurred 1 Natural (Month, Day, Year) 5 Pending work 1 Tes 2 No 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 Certifying Nurse Practioner, To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month, Day, Year) 3/28/11 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

State

DHMH 17 Rev 7/2009

Registrar

William F. Harper MD, 100 South Center Street, Thurmont, Maryland 21788

32. Registrar's Signature

Carried .

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death 19530 Physician/ Month A Filmer William Burton, Jr. 201 Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Washington County Meritus Medical Center Hagerstown Social Security Number If Under 1 Year I If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign 7, Age (In vrs. last birthday) **Funeral** 1 XM 2 □ F Hours Min. Jahr. 20 1947 Permsylvania 219-46-3715 64 Director Usual Residence of Decedent 28a-f show 10d. Inside City Limits 10b. County 10a. State 10c. City, Town or Location at within 72 hours after death with the Maryland Director must be notified 1 X Yes 2 □ No Maryland Washington County Hagerstown 10e. Street and Number ö 10f. Zip Code 10g. Citizen of What Country? items 23a Funeral 55 East Washington St. 21740 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Race - American Indian, Black, White, etc. 11. Marital Status Armed Forces?

1 Yes 2 No
If Yes, Give
Year or Dates. o, φ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify: White "natural", Completed 3 Widowed 4 X Divorced Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working Department of Health and Mental Hygene. Important: If item 27 is marked other than any injury or other traumatic event, the Me life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Property Manager Property Owner Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Filmer W. Burton, Sr. Josephine F. Crady Burton 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Tanya Crawford-daughter 13903 Sunrise Dr. Hagerstown, MD 21740 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place, 20c. Location - City or Town, State 1 Burial 2 X Cremation 3 Removal from State Smithsburg Crematory 4-4-2011 Smithsburg, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Lice 22. Name and Address of Facility Douglas A. Fiery Funeral Home 1331 Eastern Blvd. North Hagerstown, MD 21742 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest. shock, or heart failure. List only one cause on each line Onset and Death obstructive pulmonery disease Immediate Cause (Final Physician hroniz disease or condition resulting in death) Medical Due to (or as a consequence of Examiner Tabaco use Sequentially list conditions Examine if any, leading to immediate cause. Enter Underlying Due to for as a consequence of ng physician and as the burial-transit or Attending Physician: The law requires that the death certificate be executed Cause (Disease or liniury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Records, P.O. Box 68760 attending IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death
4 Pregnant at time of death
9 Unknown use 23b. Was decedent pregnant 23d Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months? ģ 2 No Yes been signed by the a 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 X Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 No page 2 s has 1 Yes 2 No 1 Yes Division of Vital funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital 1 ☐ Yes 2 X No ျ 1 Inpatient 2 K ER/Outpatient 3 IDOA this Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? s after death.

I Director: After to a in by the funeral Certificate: 28d. Describe how injury occurred 1 Natural 5 Pending injury 1 Yes 2 No 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, filled in by determined 24 hours a To the Hospital Medical 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. completed Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one) within 2 29b. Signature and title certifie 29c. License number 29d. Date signed (Month, Day, Year, 04-04-2011 45563

3H-1

Registrar

State

31. Date filed (Month,

12916 Conamar Drive Suite 204 Hagerstown Maryland 21742

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

MD

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygien ? For State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death MONth MARCH Physician/ Year Mildred P. Berry 100 A 201) Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Burtonsville Montgomery Sanctuary at Holy Cross Burtonsville 5. Social Security Number 6. Sex If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) 8. Date of Birth **Funeral** (Month, Day, Year) May 26, 1948 1 🗆 M 2 🖾 F 62 Days 212-50-7884 Maryland Director Usual Residence of Decedent or 28a-f show notified at 10c. City, Town or Location
Silver Spring 10a State 10h. County 10d. Inside City Limits the Maryland Director Maryland Montgomery 1 Yes XX No ò 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ms 23a or must be n Funeral USA 20904 14000 Castle Boulevard 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Examiner Black, White, etc ö þ Never Married 2 Married 3altimore, Maryland 21215-0036 within 72 hours after Black. 1 Yes 2 K No Specify. 'natural", 3 Widowed 4 Divorced Specify Completed oe filed wn...
Mental Hygiene.
''ed other than "natu.
"t, the Medical Ey Year or Dates 16a. Decedent's Usual Occupation 15. Decedent's Education 16b, Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Law enforcement State Trooper traumatic event, Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) and Mental I 2 should be Charles S. Berry, Sr. Henrietta Anderson 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code, Department of Health a Important: If item 27 is any injury or other tra 311 Upshur Drive, Inwood, West Virginia Charles S. Berry, Jr - brother 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place, 20c. Location - City or Town, State Page 1 1XXBurial 2 Cremation 3 Removal from State 3-28-2011 Resthaven Memorial Frederick, Maryland 4 ☐ Donation 5 ☐ Other (Specify) Sign were of Funeral Service Licensee 22. Name and Address of Facility Stauffer Funeral Home 1621 Opossumtown Pike, Frederick, Maryland 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Interval Between Immediate Cause (Final HRONIC Onset and Death STRUCTIVE Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions. in any, leading to immediate cause. Enter Underlying Cause (Disease or linjury Due to for as a conseduence on. transit death certificate be executed and that initiated events physician ar s the burial-t resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 attending ph I for use as th IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Dav Year 5 Other (specify) Pregnant at time of death 2 No the 9 Unknown g Unknown signed by t d be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death Completed by 1 Yes 2 No 3 Probably 4 Unknown page 2 should 24b. Were autopsy findings available prior to completion of cause of 24a. Was an Physician: The law After this certificate has autopsy perform Yes 2 No 1 Yes PNo 25. Was case referred to medica examiner? completed filled in by the funeral director, æ 26. Place of Death (Check only one) Hospital a No Other: 욘 1 🗌 Yes 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of e Hospital or Attending Pl 124 hours after death. e Funeral Director: After th 28c. Injury at Certificate: 28d. Describe how injury occurred Natural iniury 5 Pending work? 1 ☐ Yes 2 ☐ No Accident Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. within 2 To the I only one 29b. Signature/and title of certifie 29c. License number 29d. Date signed (Month. Day, Year) 28595 MI seeces 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) MD 2835 21209 TASNEE MD Registrar's Signature State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygien® State
Registrar Amend#20b. PerFHPGC4-6-11cr Certificate of Death 2. Date of Death 3 Time of Death Physician/ Medical 4a. Facility Name (if not ir stitution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** 13009 Crocker Place Prince George's Upper Marlboro Social Security Number If Under 1 Year If Under 24 Hrs. 8, Date of Birth 9. Birthplace (State or Foreign 6. Sex 7. Age (In vrs. last birthday **Funeral** Days Hours Min Country) Illinois 1**X** X M 2 □ F 087027 1929 81 333-22-4470 **Director** Usual Residence of Decedent 28a-f shov 10b. County 10d. Inside City Limits 10a. State 10c. City, Town or Location Director ms 23a or 28a-f s must be notified 1 Yes 2X No Prince George's Upper Marlboro Maryland | 10e. Street and Number 10g. Citizen of What Country? USA Funeral 20774 13009 Crocker Place Page 1 and 2 should be filed within 72 hours after death v ment of Health and Mental Hygiene. 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. þ "natural", or 1 Never Married 2XX Married 1XXYes 2 ☐ No If Yes, Give Baltimore, Maryland 21215-0036 1949 White 1 ☐ Yes 2XX No Specify Specify: Completed 3 Widowed 4 Divorced Year or Dates. $197\overline{9}$ 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Lt. Col. USMC Military years Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) marked o ည 01sen Victoria Lila Bjork Raymond Verner 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 sh Department of Health ar Important: If item 27 is any injury or other trau once. 13009 Crocker Place Upper Marlboro, Maryland 20774 Mary C. Bjork / Wife 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 5-10-2011 ¹XX Burial 2 ☐ Cremation 3 ☐ Removal from State Ünknown Arlington, Virginia 4 ☐ Donatign 5 ☐ Other (Specify) Arlington Nat. Cem. 21. Signature of Funeral Service Licenses 22. Name and Address of Facility George P. Kalas Funeral Home PA alas 6160 Oxon Hill Rd. Oxon Hill, Maryland Approximate Interval Between Onset and Death 23a Par 1. Enter the disea of or complications traticaused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause of each line. Immediate Cause (Final Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of): that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical P.O. Box 68760 attending pl IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?

1 Yes 2 No Year Month Day Pregnant at time of death Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Records, 1 Yes 2 No 3 Probably 4 Unknown Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 Yes 2 No Division of Vital Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital Other: 2 1 🗌 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at work? 28d. Describe how injury occurred 1 Natural 2 Accident 5 Pending s after death.

I Director; Af
d in by the fu 1 Yes 2 No Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f, Location (Street and Number or Rural Route Number, determined Medical 29a. Certifier 1 💢 certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. within 2 To the 29b. Signature and title of certifier 10+1 rson who completed cause of death (Item 23a) (Type, Print 6934 Aviation Blvd State Registrar

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Month **Physician** 12:26 PM March 30, 2011 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Charles LaPlata Charles County Nursing Center If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) 02/26/1926 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** Hours ¥ M 2 □ F Washington, DC 85 579-24-1854 Director Usual Residence of Decedent 10d. Inside City Limits 10c. City. Town or Location 10b County 10a. State 28a-f show if of Health and Mental Hygiene.
If item 27 is marked other than "natural", or items 23a or 28a-f shoy or other traumatic event, the Medical Experiment must be notified at 1 ☐ Yes 21XNo Waldorf Director Charles Maryland 10g, Citizen of What Country? 10e. Street and Number 10f. Zip Code USA 20601 3003 Walnut Lane Funeral hours after death Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status 12. Was Decedent Ever in U.S. was becedent Ev Armed Forces? 1 ∐Yes 24 ANo Black, White, etc. 1 ☐ Never Married 2 ☐ Married Saltimore, Maryland 21215-0036 White If Yes, Give Year or Dates: 1 ☐ Yes 2 🙀 No Specify Snecify: 2 3x Widowed 4 ☐ Divorced Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) filed within 72 h Hygiene. (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Cemetery Caretaker 4 years 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) permit. Pages 1 and 2 should be file Department of Health and Mental H Important: If item 27 is marked oth any injury or other traumatic even Be С. Bea11 Olive Richard 2 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3003 Walnut Lane Waldorf, Maryland 20601 Dorothy Bennett / Sister 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition XX Burial 2 ☐ Cremation 3 ☐ Removal from State 04/04/2011 | Suitland, Maryland Cedar Hill Cemetery 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility George P. Kalas Funeral Home PA Fune Pervice I 20745 6160 Oxon Hill Rd. Öxon Hill, Maryland Approximate Interval Between Onset and Death 23a. Path. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) ongenive **Physician** /Medical Due to (or seguence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a possequence of Examiner ibrillation nal death certificate be executed burial-transit and Due to (or as a consequence of) physician the burial Box 68760. Physician/Medical attending pl IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death
4 Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month in the past 12 months? 1 ☐ Yes 2 ☐ No Day P.O. мтет тиз certificate has been signed by the funeral director, page 2 should be detached 9 I Inknown 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, ۾ hunestension 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 0 24a. Was an autonsy perform Hoem 1 ☐ Yes 2 DNo 1 ☐ Yes Physician: 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DCA Certification: To 28a. Date of Injury (Month, Day, Year) 27. Manner of D ath 28c. Injury at Work? To the Hospital or Attending Pt within 24 hours after death.
To the Funeral Director: After th completely filled in by the funeral 28b. Time of 28d. Describe how injury occurred 5 Pending 1 ☐ Yes 2 TNo 2 Accident investigation 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical (Check only one) 29c. License number 29b. Signature and title of certifier 71199 Type, Print) tes Colony Drive i.A. Annapolis, my 21401 Josjin Vanha 31. Date filed (Month, Day, Year) State

DHMH 17 Rev 1/2001

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Day \mathbf{P}^{M} March Medical Francis Joseph Behr 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Wicomico Salisbury Titlest Drive Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 M 2 □ F Months Days Hours Min 12104 11923 219-12-5227 Maryland **Director** 87 Usual Residence of Decedent ar ment of Health and Mental Hygiene. or them 27 is marked other than "natural", or items 23a or 28a-f show in lury or other traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Page 1 and 2 should be filed within 72 hours after death with the Maryland Director 1 Yes 2 X No Salisbury Maryland Wicomico 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral USA 21801 Titlest Drive 11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14 Bace - American Indian. Armed Forces If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ▼ Yes 2 No
If Yes, Give Merchant Completed by 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 Yes 2 X No Specify: Specify: White 3 Widowed 4 Divorced Year or Dates Marine 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15 Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Assembly Line Worker Dresser Wayne Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Louise Unknown Gerard Behr 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 606 Pacific Ave., Sailsbury, Maryland 21804 Behr|son Steven 20b. Place of Disposition (Name of cemetery, crematory or other place)
Salisbury Crematory 20a. Method of Disposition Date 20c. Location - City or Town, State ☐ Burial 2 🔀 Cremation 3 ☐ Removal from State 103 25 2011 Salisbury, Maryland 4 ☐ Donation 5 ☐ Other (Specify) Departiments Importa 22. Name and Address of Facility Holloway Funeral Home P.A. 501 Snow Hill Rd., Salisbury, Maryland 21804 Licensee CFSP MARIA . Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, 23a. Part 1 shock, or heart failure. List only one cause on each line Interval Between Onset and Death Immediate Cause (Final MALIGNANT PROSTATR Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner Sequentially list conditions Examine if any loading to immedicause. Enter Underlying Cause (Disease or iinjury Due to lor as a consequence of To the Hospital or Attending Physician: The law requires that the death certificate be executed use as the burial-transi that initiated events resulting in death) Last Due to (or as a consequence of) After this certificate has been signed by the attending physician funeral director, page 2 should be detached for use as the burial Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No Month Day Pregnant at time of death 5 Other (specify) 9 Unknown Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 🗌 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a. Was an autopsy performed Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? 2 1 100 은 ER/Outpatient 3 DOA 1 Inpatient 2 I 4 Nursing Home 5 Residence 6 Other (Specify) within 24 hours after death.

To the Funeral Director, After this completed filled in by the funeral of 28a. Date of injury (Month, Day, Year) Certificate: 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred 5 \square Pending work? 1 Yes 2 No Natural Accident Investigation 6 Could not be Suicide Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) INA 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 00 BUX 20 32, Registrar's Signatur State Registrar

			Please	Type or Pri					-		.egible.		
			For State Registrar	State of Ma	aryland		artment of tificate of	Health and Death	Mental Hy	giene Reg. No	Contractor of the Contractor o	12078	
	Physicia Medic		1. Decedent's Name (First, Middle, Las Delores J.	Barksda]	le				2. Date of De Month		Year I	3. Time of Death	
	Examir		4a. Facility Name (if not institution, give		(i) (a	aniar	4b. City, Town,	or Location of Deatl	h /	4c. Co	ounty of Death	0.0	
	Funeral		5. Social Security Number 6. Se	X 7. Age ☐ M 2 🔀 F		et birthday)	If Under 1 Year Months Days			th V	g. Birth	nplace (State or Foreign	
	Director		216-82-1020 1 Usual Residence of Decedent		51	Yrs.			08/07/1	1949	Wes	t ^{rry)} Virginia	
	ryland I-f shov ied at	ctor	10a. State 10b. County		,	Town or Loc						10d. Inside City Limits 1 Yes 2 □ No	
	the Ma or 28g	Dire	Maryland Wicomi 10e. Street and Number			lisbur	10f. Zip Code				n of What Cou		
	orth with ms 23a must b	Funeral Director	927 E. Church S	t., Apt. A		112 1	2180)4 Hispanic Origin? (Sp	posify Vos or No		SA		
98	fter dea , or ite aminer	þ	11. Marital Status 1 Never Married 2 Married	Armed Forces? 1 Yes 2 If Yes, Give		H	Yes, specify Cub	an, Mexican, Puert	o Rican, etc.)		. Race - Ameri Black, White	, etc.	
-00	nours a natural' ical Exi	Completed	3 Midowed 4 □ Divorced 15. Decedent's Ed	Year or Dates.		16a. Deced	lent's Usual Occu	pation	****		ecify: W]	hite	
1215	hin 72 h ne. than "n ie Medi	dwo	(Specify only highest gra	de completed) College (1-4 or 5	+)	(Give F life. D	kind of work done D NOT use retired emaker	during most of wor)	rking		omestic		
d 2	iled wit I Hygie other ent, th	Be	17. Father's Name (First, Middle, Last)					18. Mother's Nar	me (First, Middle,				
ylan	uld be fi Menta narked natic ev	인	David M. Helmick			,		Elene Stevenson					
Baltimore, Maryland 21215-0036	1 and 2 should be filed within 72 hours after death with the Maryland of Health and Mental Hygiene. item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at		19a. Informant's Name/Relationship (Ty Michael Barksdal	,	and Number or Ru ch St., S				Code)				
nore	age 1 ar ent of Ha t: If iten / or oth		20a. Method of Disposition 1 ☐ Burial 2 😾 Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specification 2)	Removal from State	ce	metery, cren	sition (Name of natory or other pla Cremato		Date 8/2011		sbury,		
altir	permit. Page 1 and Department of Hambortant: If its any injury or ot once.		21. Signature of Funeral Service Licen	2/	Jai.								
<u></u>	99 = # 9		23a. Part 1. Enter the disease, or comp	Munu	the death						MD 218	ssociation 04	
, maring	Physician/	0. 0	shock, or heart fallure. List only or Immediate Cause (Final disease or condition	ne cause on h line	PI		, ale mede et dy	ng, odon do odrada	o or reopriatery ar	1000,		Interval Between Onset and Death	
	Medical Examiner		resulting in death)	a. Due to (or as a	conseque	ence of):							
D.		iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (uisease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of):										
	executed an and rial-transil	Examine											
09,		dical	d										
09289	death certificate be ne attending physici ed for use as the bu	n/Me	23b. Was decedent pregnant	23c. If yes, outcome	of pregnan		Ectopic pregnar	2004		230	d. Date of deliv	very	
_	ed ed	Physician/Medical	in the past 12 months? 1 ☐ Yes 2 D No 9 ☐ Unknown	4 Pregnant a			Other (specify)				Month	Day Year	
			Part II. Other significant conditions co	ntributing to death b	ut not resu	Iting in the u	nderlying cause g	iven in Part I.				the cause of death?	
Division of Vital Records,	The law requires that ate has been signed b page 2 should be det	Completed by							24a. Was		24b. Were auto	opsy findings available	
Rec	ii cian: The law certificate has rector, page 2	Comp								psy ormed? 2 No	death?	ompletion of cause of 2 No	
/ital	Physician: this certific ral director,	o Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 No	Hospital:	o X =	- D/O		Place of Death (Che			lou o		
of/	ng Phy fter this ineral d	ate: To	27. Manner of Death 1 Natural 5 □ Pending	28a. Date of injui (Month, Day	ry 2	28b. Time of injury	28c. Inju	ry at	lome 5 Resident Resid			<u> </u>	
sion	Attendi death ctor; A	Certificate:	2 Accident Investigation 3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Inju	ıry - At hom	ne, farm, stre		Yes 2 No	28f. Location (Street and N	umber or Rura	al Route Number,	
Divi	To the Hospital or Attending Physiciam: within 24 hours after death of the Funeral Director. After this certific completed filled in by the funeral director,			building, etc					City or Tov	vn, State)			
	he Hospital in 24 hours a he Funeral I	Medical		ner: On the basis of ex	xamination :	and/or invest	igation, in my opin	ion, death occurred	at the time, date a	and place, an	nd due to the ca	ause(s) and manner stated.	
	To the I within 2 To the I comple		29b. Signature and title of certifier	1			29c. Licen:	se number		29d. Date s	igned (Month,	Stated. Day, Year) 20 11	
			30. Name and address of person who c	ompleted cause of de	eath (Item 2	23a) (Type, P	rint)	, , ,		1 ,	20/	XV //	
	Stat	· a	Mitch EX S. (31. Date filed (Month, Day, Year)	32. Registra	r's Signatu	0 10	DE, CAR	roll s	T SALI	SHUR	24 Mc	121801	
	Registra	ar	31. Date filed (Month, Day Year) MAR 30	2011 Jan	wi	P. 6	Barke						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			For State Registrar	State of N	Maryland		artment of H tificate of D		nd Mental I	Hygiene Reg. No.	011	12079	
			Decedent's Name (First, Middle	e, Last)					2. Date o	f Death		3. Time of Death	
	Physicia Medic		Milto	n Monroe Bl	ank				Alerth.	ll Pay	20 1 21	9:00 P _M	
	Examin		4a. Facility Name (if not institution Frederick	n, <i>give street and number,</i> Memorial Ho			4b. City, Town, or Fr	Location of I		4c. 0	County of Dear Frede	rick	
	Funeral Director		5. Social Security Number 220–03–1438	6. Sex 1 XM 2 F	Age (In yrs. lasi 88	t birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hours		Birth , <i>Day</i> , Year) 20, 19 2	g. Bir Co Ma 1	thplace (State or Foreign untry) ryland	
	d how it	ايا	Usual Residence of Decedent 10a. State 10b. County	,	10c. City.	Town or Loc	cation					10d. Inside City Limits	
	arylan a-f sk fied a	[6	,	rederick	1,			derick		1 🗌 Yes 2 🛣 No			
	ith the Ma 23a or 28 st be noti	Funeral Director	10e. Street and Number 7819 Old Receiver	Road			10f. Zip Code	21702		10g. Citizen of What Country? United States of America			
	eath w	-ine	11. Marital Status	12. Was Deceden		13. V	Vas Decedent of His	spanic Origin	n? (Specify Yes or	No- 1	4. Race - Ame		
Q	ter de , or it	by	1 ☐ Never Married 2 ☐ Ma	Armed Forces 1 Yes 2 If Yes, Give	no Worl d	a I	f Yes, specify Cubar ☐ Yes 2 ♣No		Puerto Rican, etc.		Black, Whit	Same 1	
3-003g	ursaf tural" al Exa	Completed	3 ▲Widowed 4 □ Divorce	Year or Dates		TT					specify:	White	
<u>,</u>	72 ho "na" r ledica	nple	(Specify only high	ent's Education est grade completed)		(Give k	lent's Usual Occupa kind of work done d O NOT use retired)	ation <i>uning m</i> ost o	of working	16b. Kin	d of Business	Industry	
7	ithin iene. r thar the M	ပ္ပ	Elementary/Seconday (0-12)	College (1-4 o	r 5+)		Mason				Construc	tion	
2	iled w Hygi othe ent,	Be	17. Father's Name (First, Middle,	Last)					's Name (First, Mic				
/land	d be f Menta arked	2	Hilton H. B	Lank]	Elizabeth	Viola Lo	wery		
Mar	and 2 shoul Health and I tem 27 is ma other traums		19a. Informant's Name/Relations Latricia Reddish			19b. Mailin 4102 T	ig Address (Street a Ceak Place,	West S	or Rural Route Nu alem, Ohio	mber, City or 7 44287	own, State, Zi	p Code)	
salumore,	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Heath and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.		20a. Method of Disposition 1 Burial 2 □ Cremation 4 □ Donation 5 □ Other (to cer	netery, cren	sition (Name of natory or other place ngs Cemeter)	e) y Ap :	Date ril 12, 20		eation - City or erick, M		
palri	permit. F Departm Importa any inju	3	21. Signature of Funeral Service	-	M014	33 ²² K	Name and Address eeney & Bar 106 East Chr	sford P urch St	.A. Funera	l Home erick, M	aryland	21701	
	te be executed Medical Medical Askidan and Barutal-transit	al Examiner	Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if the line immediate cause. Enter Underlying Cause (Disease or linjury that initiated events resulting in death) Last	b. Due to lor a	as a conseque	nce of):	s TRUCT	VE P	ucnow	acy E	OL SEAN	Onset and Death	
. Box 68/60	To the Hospital or Attending Physician; The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No g □ Unknown		h 2 Fetal It at time of de	death 3 🗌	Ectopic pregnanc Other (specify)	у			3d. Date of de Month	blivery Day Year	
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Records,	he law red ite has be vage 2 sho	Completed by	HYPERTEN	(dean						Was an autopsy performed? Yes 2 No	prior to death?	utopsy findings available completion of cause of	
VITAL	ian; T	Be	25. Was case referred to medica examiner?	-				-	(Check only one)				
5	hysic his ce	은	1 Yes 2 No		atient 2 E			4 ∐ Nur	sing Home 5			cify)	
1 OT	ling P	ate:	27. Manner of Death 1 Natural 5 Pend	ing .	njury Day, Year)	28b. Time of injury	work	?		ibe how injury	occurred		
UIVISION	or Attend after death Director: / in by the I	Certificate:	3 Suicide 6 Could	mined 28e. Place of	Injury - At hom etc. (Specify)	ne, farm, stre	M 1 L	Yes 2 N	28f. Locat	ion (Street and r Town, State)	Number or Ru	ural Route Number,	
ב	e Hospital 124 hours 9 Funeral leted filled	edical	(Check 2 Medical	g Physician: To the best Examiner: On the basis of g Nurse Practioner: To t	of examination	and/or invest	tigation, in my opinic	on, death occ	urred at the time, o	late and place,	and due to the	cause(s) and manner stated.	
	To th withir To th	Σ	29b. Signature and title of certific		MD		29c. License	e number	· . <u>.</u> ·	29d. Date	signed (Moni	th, Day, Year)	
			30. Name and address of person	who completed cause of	of death (Item 2	23a) (Type, F			REDERI	ck,	MD.	21702	
	Sta Registr	te ar	30. Name and address of person A. D 6 N E LSO 31. Date filed (Month, Day, Year)	PR 1 4 2011	strar's Signatu	ire	1. par	1					

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death ^{Day} 2011 Physician/ April 7:58 Car1 Leroy Boore 6 a Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Washington Williamsport Nursing Home Williamsport Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign 7. Age (In vrs. last birthday) Funeral Country) Pst <u>Virginia</u> Davs (Month, Day, Year) 4/29/1932 1 **X**M 2 □ F Director 78 218-30-0786 West Usual Residence of Decedent show or 28a-f show notified at 10a. State 10c. City, Town or Location 10d. Inside City Limits Director 1 X Yes 2 □ No MD Washington Hagerstown 10e. Street and Number 10g. Citizen of What Country? items 23a or ner must be n 9 10f. Zip Code Funeral 1025 Georgia Avenue 21740 U.S.A. death 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14 Race - American Indian 11. Marital Status er than "natural", or iter the Medical Examiner Armed Forces?

1 Yes 2 If Yes, Give
Year or Dates. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. 1 Never Married 2 Married δ 2 No within 72 hours after Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify. Specify 3 Widowed 4 Divorced Completed White 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working ige 1 and 2 should be filed within 72 nt of Health and Mental Hygiene.

E: If item 27 is marked other than or other traumatic event, the Me life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) <u>Sheet Metal Worker</u> Metal Work Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ James Boore Mabe1 Landis 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Lisa Stoneking / Daughter 16113 Everly Road, Hagerstown, MD 21740 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place)
Rest Haven Cemetery 20c. Location - City or Town, State Page 1 Burial 2 Cremation 3 Removal from State Department o Important: If any injury or 4/9/2011 Hagerstown, Maryland ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Rest Haven Funeral Chapel Pennsylvania Ave., Hagerstown, Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. 23a. Part 1. Enter the disease, or complica Approximate Interval Between Onset and Death Immediate Cause (Final ENDSTAGE Ph_sician/ OBSTRUCTIVE PULMONARY DISEASE CHIZONIC disease or condition resulting in death) Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Examiner Due to (or as a consequence of) Hospital or Attending Physician: The law requires that the death certificate be executed 24 hours after death.

Francis Innered Director: After this continous hours. -transit that initiated events resulting in death) Last Due to (or as a consequence of) by the attending physician a tached for use as the burial-Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death
4 Pregnant at time of death
9 Unknown 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?
1 ☐ Yes 2 ☐ No Day Year Month detached 9 Unknown signed to Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 XYes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an performed? Yes 2 No 1 ☐ Yes 2 ☐ No 25. Was case referred to medical Certificate: To Be 26. Place of Death (Check only one) examiner? 2 X No Other: 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) within 24 hours after death.

To the Funeral Director: After thi
completed filled in by the funeral i 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28c. Injury at 28b. Time of 28d. Describe how injury occurred 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No Accident Investigation Suicide 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier Dowe MD D33700 APRIL 2011 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar

DHMH 17 Rev 7/2009

State

HOWE

31. Date filed (Month, Day, Year)

ORIGINAL

AZTIZAN ST

WILLIAMSPORT, MD

154

32. Registrar's Signature

N

Please Type or Print in Black Indelible Ink, Ensure All Copies Are Legible.
State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. . Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death MARCH 22, 2011 Physician/ 1:45 A M ETHEL VIRGINIA CAIN Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner KENT CHESTER RIVER MANOR CHESTERTOWN If Under 1 Year If Under 24 Hrs. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 🗆 M 2 💢 Hours 08/17/1916 MARYLAND **Director** 94 222-12-8775 Usual Residence of Decedent 28a-f shov iral", or items 23a or 28a-f sho 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits with the Maryland Director 1 Yes 2X No MILLINGTON KENT MD 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral UNITED STATES 33206 CYPRESS ROAD 21651 death 13. Was Decedent of Hispanic Origin? (Specify Yes or No-12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian Armed Forces?

1 Yes 2 No
If Yes, Give
Year or Dates. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. þ 1 Never Married 2 Married permit. Page 1 and 2 should be filed within 72 hours after Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or any injury or other traumatic event, the Medical Examin Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: 3X Widowed 4 □ Divorced Specify: Completed BLACK 15. Decedent's Education 16a, Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) GUIDANCE COUNCELOR **EDUCATION** Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည MARY GRACE BRATCHER DENNIS ALEXANDER CLARK 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) ALVIN CAIN / STEP SON 11489 REED CIRCLE RIDGELY, MARYLAND 21620 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 XBurial 2 Cremation 3 Removal from State cemetery, crematory or other place, 4 ☐ Donation 5 ☐ Other (Specify) PLEASANT CEMETERY 03/28/2011 MILLINGTON, MARYLAND MT. 21. Signature of Funeral Service Licensee 22. Name and Address of Facility
FELLOWS, HELFENEBIN & NEWNAM FUNERAL HOME. P.A.
370 WEST CYPRESS STREET MILLINGTON, MARYLAND21651 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Autorio Sclevatic Condio Vascular Discour Immediate Cause (Final Physician/ disease or condition years Medical resulting in death) Due to (or as a consequence of Examiner Sequentially list conditions, Examiner cause. Enter Underlying Cause (Disease or iinjury Due to for as a consequence of a law requires that the death certificate be executed attending physician and for use as the burial-transit that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 3 Ectopic pregnancy
5 Other (specify) 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?
1 Yes 2 No Month Dav Year Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ HXCVA: MTN: ACholi 1 ☐ Yes 2 ☐ No 3 X Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy certificate ha lirector, page 2 performed? To the Hospital or Attending Physician: The I within 24 hours after death.

To the Funeral Director: After this certificate h 2 X N Yes 25. Was case referred to medical B B 26. Place of Death (Check only one) Hospital: Other: 42 Nursing Home 5 Residence 6 Other (Specify) 2. No 1 Yes မ 1 Inpatient 2 I ER/Outpatient 3 I DOA 28c. Injury at work? 1 ☐ Yes 2 ☐ No 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28d. Describe how injury occurred injury 1 X Natural 5 Pending Accident Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Medical 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check within 2

To the I

complete only one) 29b. Signature and title of certifier 29c. License number 29d, Date signed (Month, Day, Year) D0050996 2011 5 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Stoddard 54. 21620 31. Date filed (Month State Registrar

		For	Plea	ase 1				d / Dep	artmen	t of H	lealth		III Copie Mental Hy		_	ible.		
		State Registrar 1. Decedent's Nam	e (First, Middl	e, Last)				Ce	rtificate	of E	Death		2. Date of D	Reg. N	<u>5</u> Û	Pendi	3. Time of 0	82 Death
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Funeral Director		5. Social Security N		6. Sex	M 2 X F	7. Age		st birthday) Yrs.	If Under Months	Days	If Under Hours	Min.	8. Date of Bi (Month, D 04/05	av. Year)		9. Birth Cour	olace (State or stry) JERSEY	Foreign
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and 2 Health em 2; ther t		DORIS C. 20a. Method of Disp		L /	DAUGH	TER	20h B	2526 lace of Dispo			PT. I	-	BETTER				own, State	
permit. Page 1 and 2 st Department of Health a Important: If item 27 is any injury or other tra		1X Burial 2	☐ Cremation		emoval from	n State	C	emetery, cre	natory or ot	ther place	i		Oate					
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Physician/		23a. Part 1. Enter t shock, or hea Immediate Cause disease or condition	rt failure. List (Final	r complic only one	etions that cause on e	caused ach line	the death	n. Do not ent	0	of dying		cardiac d	or respiratory a	rrest,			Approximate Interval Betw Onset and De	reen
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To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit	Completed by Physician/Medica	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown 1 Unknown 23c. If yes, outcome of pregnancy 23d. Date of 23d. Date of Month Month 25d. Month 25d.												ery Day Ye	ar			
that the	y Ph	Part II. Other signif	ficant conditi	ons con	ributing to d	death bu	ut not res	ulting in the I	underlying c	ause giv	en in Part	I	23e. Did	tobacco	use cont	ribute to t	ne cause of dea	ath?
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Hospi 24 hou Funer sted fill	Medical		☐ Medical !	Examine	r: On the ba	sis of ex	amination	and/or inves	tigation, in n	ny opinio	n, death o	ccurred at		and plac	e, and du	e to the ca	use(s) and man	ner stated
o the vithin 2 o the o the omple	Ň	only one) 3 29b. Signature and		_	Practioner:	To the b	est of my	knowledge,			e time, date number	e and plac	e, and due to t			anner as si		
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		30. Name and addr	ss of person	JUN MIIO COL	MD.	se oi de	600) (Type, I	irch	Hil	1 RA	. Ch	restert	JNC	M	D 2	1620	
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Registrar DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene for State Registrar Certificate of Death 2. Date of Death Decedent's Name (First, Middle, Last) Physician/ an $m\alpha$ Medical Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Peath **Examiner** 0 8. Date of Birth (Month, Day, If Under 24 Hrs. 9. Birthplace (State or Foreign Age (In yrs. last birthday) **Funeral** 1 □ M 2 □**X** 74 Days Hours Min. 217-36-1947 MD Director /24/1937 Usual Residence of Decedent 27 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Examiner must be notified at 10d. Inside City Limits 10c. City, Town or Location 10b. County 10a. State within 72 hours after death with the Maryland Director Kennedyville, MD MD Kent 1 🗌 Yes 2 🔀 No 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number Funeral 21645 USA 11673 Kennedyville Road Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? Black, White, etc. 1 ☐ Yes 2 🔀 No If Yes, Give Completed by 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify: Black 3 Widowed 4 Divorced Year or Dates 16a. Decedent's Usual Occupation 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) and Mental Hygiene. is marked other than Elementary/Seconday (0-12) College (1-4 or 5+) Homemaker <u>Homemaker</u> Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) ပ္ Tiller Rebecca Boyer Samuel 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Department of Health Important: If item 27 105 Kenndy Drive Chestertown, MD 21620 Floyd injury or other 20b. Place of Disposition (Name of cemetery, crematory or other place)
MT Zion U.M. Church 3/26/11 20c. Location - City or Town, State 20a. Method of Disposition 1 X Burial 2 Cremation 3 Removal from State Still Pond, 4 ☐ Donation 5 ☐ Other (Specify) Cemetery 22. Name and Address of Facility Bennie Smith Funeral Home permit. 21. Signature of Funeral Service Licenses 855 High ST Chestertown, MD 21620 Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line Interval Between Onset and Death Immediate Cause (Final disease or condition Shock Physician/ PTIC Medical resulting in death) Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examiner Due to (or as a consequence of) sician and burial-transit that the death certificate be executed Cause (Disease or linjury that initiated events Due to (or as a consequence of) resulting in death) Last attending physician for use as the buria Physician/Medical Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b, Was decedent pregnant Live Birth 2 Fetal death 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No 5 Other (specify) Pregnant at time of death 9 Unknown P.O. s been signed by should be detailed Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by De Cubitus U/cen 1 Yes 2 No 3 Probably 4 Unknown Records, Acute Renal failure 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an To the Funeral Director: After this certificate has completed filled in by the funeral director, page 2 s performed bowel Ischemic 1 Yes 2 No 25. Was case referred to medical examiner?
1 ☐ Yes 2 ☑ No Division of Vital 26. Place of Death (Check only one) Be Other: 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA ၉ 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Hospital or Attending 1 Natural work? 5 Pending 1 Yes 2 No 24 hours after death Funeral Director: A 2 Accident
3 Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined 1 🙇 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the unite, date and place, and due to the cause(s) and manner as stated.

3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifier D0069417 12011 MD 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Dr. Samantha Kalakurthy, 100 brown street, Chestertown, MD 31. Date filed (Month, Day, Year) State Registrar

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

		For State Registrar	State of I	Maryland .		artment of H			ene	A Company	12084	
		Decedent's Name (First, Middle	le, Last)					2. Date of Death	1	N	3. Time of Death	
Physic /Med		Ralph	Ca	landre1	1a			Month 2	8 2C	Year 11	11:37 p ^M	
Exami		4a. Facility Name (If not institutio	n, give street and numb	er)		4b. City, Town, or	Location of Dear	h	4c. Count	y of Death		
1		Oakland Nursi	ng & Rehab	Center		0akla			Garret	:t		
Funeral Director		5. Social Security Number 214–36–6657		Age (In yrs. last	t birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs Hours Min.		Year) 1937	9. Birthp Court C'	place (State or Foreigntry) Γ	
pu »		Usual Residence of Decedent 10a. State 10b. County		10- 0it- T	F 1 -					1.	0d. Inside City Limits	
aryla sho	5	10a. State 10b. County WV Mines		10c. City, T	Gare					1'	1 ☐ Yes 2 W No	
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ie 4	by Funeral Director	1 Never Married 2 Mar 3 Widowed 4 Divorced	ried Armed Force	s? X No		Was Decedent of Hi If Yes, specify Cuba 1 □Yes 2 No	Specify:	to Rican, etc.)		ick, White, e	etc.	
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e filec all Hyg othe vent,	Be C	17. Father's Name (First, Middle,	Last)			•	18. Mother's Na	me (First, Middle, M	laiden Surna	me)		
Juld be f Mental arked o	10	Ralph Caland	rella, M.D.				Mary V	/irginia N	Weicht			
s ma	-	19a. Informant's Name/Relations	ship (Type. Print)		19b. Maili	ng Address (Street a	and Number or A	ural Route Number,	City or Town	n, State, Zip	Code)	
and 2		Carolyn Caland	rella-wife		RT	1 Box 239	, Elk Ga	rden, WV	26717	7		
ges 1 and 2 should be filed within 72 ho it of Health and Mental Hygiene. If Item 27 is marked other than "natur or other traumatic event, In Medical		20a. Method of Disposition		20b. Place	e of Dispo	osition (Name of matory or other place	9)	Date 2	20c. Location	- City or To	wn, State	
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permit. Pages 1 and 2 Department of Health 6 Important: If Item 27 Is any Injury or other tra		21. Signature of Funeral Service Licensee 22. Name and Address of Facility David A. Burdock Funeral 21. N. Second St., Oakland, MD 21550										
	8 1	23a. Part 1. Enter the disease, or shock, or heart failure. List	complications that cause only one cause on each	sed the death. In line.							Approximate Interval Between Onset and Death	
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ıyslci iis cer direci	o B	examiner? 1 ☐ Yes 2 ☐ No	Hospital:	atient 2 ☐ ER	/Outpatie	nt 3 DOA Othe		Home 5 Reside		ther (Specif	5/1	
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I or Attending Phater death. Director: After th	ific	3 ☐ Suicide 6 ☐ Could determ	not be ined 28e. Place of	Injury - At home	, farm, sti	reet, factory, office		28f. Location (Str		ber or Rum	al Route Number,	
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To the Hospital or within 24 hours afte To the Funeral Dirt completely filled in	edical (29a. Certifier 1 Certifyir (Check only one) 1 Medical	ng Physician: To the be Examiner: On the basi and manner	s of examination	dge, deat and/or ir	th occurred at the tin	ne, date and place pinion, death occ	e, and due to the ca urred at the time, da	ause(s) and rate and place	nanner as s , and due to	stated. the cause(s)	
To the within 2 To the complete	Me	29b. Signature and tige of certifie	r /			29c. License	number	25	9d. Date sign	ed (Month,	Day, Year)	
		14	, /			חחת	61801		1/	291	′ /	
		30. Name and address of person	who completed cause of	of death (Item 23	Ra) (Type		01001			111		
	8	Kenneth Buczy			, , , , ,		. Suite	1, 0akla	nd, MD	2155	0	
Sta	ite	31. Date filed (Month, Per 3an					,	,	-			
Regist		MAK 31	2011	strar's Signatur	. 1	arra						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3 Time of Death Physician/ toril Joseph Michael CARDILLO Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Meritus Medical Center Hagerstown <u>Washington</u> If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign 8. Date of Birth 7. Age (In vrs. last birthday) Social Security Number Funeral Month, Day, Your 28 1 🛛 M 2 □ F Months Days Hours Min Sept. Director Connecticut 58 047-48-7143 Usual Residence of Decedent 28a-f show 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits must be notified at Director 1 ☐ Yes 2x No Maryland Washington Sharpsburg o 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 23a 5011 Harpers Ferry Road 21782 USA 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No If Yes, Give 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, traumatic event, the Medical Examiner Black, White, etc. , or 1 Never Married 2 Married Completed by Baltimore, Maryland 21215-0036 1 Yes 2 X No Specify: White Specify: "natural", 3 Widowed 4 X Divorced Year or Dates 15. Decedent's Education 16a Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Il Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) Food Service Nursing Home and Mental Hygie is marked other Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Mariano Cardillo Mary Caruso 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) item 27 Elaine V. Cardillo- Daughter Department of Health Important: If item 27 any injury or other tr Bear Hill Road, Cumberland, R.I. 02864 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 1 Burial 2 X Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Hagerstown Crematory 4/4/2011 Hagerstown, Maryland 21. Signature of Funeral Service Licensee Minnich Funeral Home 22. Name and Address of Facility 415 E. Wilson Blvd. Hagerstown, Maryland 21740 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ au disease or condition Medical resulting in death) Due to (or as a consequence of): (**Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury that initiated events Examine Due to (or as a consequence of): resulting in death) Last physician a the burial-Physician/Medical Box 68760 attending p for use as t IE EEMALE 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) in the past 12 months? Month Day Year 4 ☐ Pregnant at time of death g ☐ Unknown 2 No 1 ☐ Yes 2 ☐ 9 ☐ Unknown P.O. þ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 2 00 Records, 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy performe death? Hospital or Attending Physician: The l 24 hours after death. 1 Yes 2 No Yes 2 25. Was case referred to medical **Division of Vital** 26. Place of Death (Check only one) Be examiner? 2 No Hospital Other: 1 🗌 Yes ျ 1 Dopatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) Manner of Death Date of injury 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: (Month, Day, Year) injury work?
1 Yes 2 No Natural 5 Pending Accident Director: A Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) To the Hospital o within 24 hours at To the Funeral D Medical 29a. Certifier Ecertifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifie 29c. License numbe 29d. Date signed (Month, Day, Year) Name and address of person who come eted cause of death (Item 23a) (Type, Print)

DHMH 17 Rev 7/2009

State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene. For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2 Date of Death 3. Time of Death Physician/ March 2 Cil 505M V. Colleen Colman Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Washington Meritus Medical Center Hagerstown Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In vrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign Funeral 1 M 2 KF Days Hours Min (Month, Day, Y February 7 009-32-3172 65 Director Vermont Usual Residence of Decedent 10a State 10b. County 10c. City. Town or Location 10d. Inside City Limits Director or 28a-f sl Maryland Washington Co. Hagerstown 1 Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 0 ms 23a or must be r Funeral 16904 Alcott Road 21740 USA ral", or items 2 12. Was Decedent Ever in U.S Armed Forces? 1 ☐ Yes 2 X No 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc 1 Never Married 2 Married Completed by 1 Yes If Yes, Give 72 hours after 21215-0036 1 ☐ Yes XX No Specify. Specify: White 3 Widowed 4 X Divorced Year or Dates event, the Medical 16a. Decedent's Usual Occupation Decedent's Education 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Technician Manufacturing other Be Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Mental ပ E11a Arena Howard Malaney 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Terri L Esperance (daughter) Baltimore, 20a. Method of Disposition
1 ☐ Burial 2 ★ Fremation XX Removal from State 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date Page 1 Dugain Funeari Home & Crematory Shippensburg, Pennsylvania 12011 Donation 5 Other (Specify) 22. Name and Address of Facility
Lochstampfor Funeral Home, Inc.
48 S. Church Street, Waynesboro, of Funeral Service Licenses M-00849 23a. Part 1. Enter the disease, or complications that caused the dean. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. 7268Approximate Interval Between Immediate Cause (Final Onset and Death Physician/ e disease or condition Medical resulting in death) Examiner cellulitis Sequentially list conditions, Examine if any, leading to immediate cause. Enter Underlying death certificate be executed the burial-transit Cause (Disease or linjury that initiated events and Due to (or as a consequence of) resulting in death) Last attending physician for use as the burial Physician/Medical Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy
5 Other (specify) 1 ☐ Live Birth 2 ☐ Fetal deat 4 ☐ Pregnant at time of death 9 ☐ Unknown in the past 12 months?
1 Yes 2 No Day Month Year 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown Records, 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy page death? or Attending Physician: The lafter death. 2 🗆 No Yes 25. Was case referred to medical **Division of Vital** Be 26. Place of Death (Check only one) examiner? Hospital Other: 2 No 1 🗌 Yes ဂ္ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death Date of injury Time of Certificate: 28c. Injury at 28d. Describe how injury occurred within 24 hours after death.

To the Funeral Director: After (Month, Day, Year) injury work? 1 ☐ Yes 2 ☐ No Natural 5 Pending Accident Investigation 3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined Hospital Medical 29a. Certifier 🗗 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one 29b. Signature and title of 29d. Date signed (Month, Day, Year) m 30. Name and adoress of person who completed cause of death (Item 23a) (Type, Print) 21742 hmann, MD 31. Date filed (Month, Day, Year)

DHMH 17 Rev 7/2009

State Registrar

State of Maryland / Department of Health and Mental Hygien Certificate of Death 2. Date of Death 3. Time of Death Physician/ Gary N. Culver рм 4:55 March Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Wicomico 1848 Saint Lukes Road Salisbury Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth 7. Age (In vrs. last birthday) g Birthplace (State or Foreign **Funeral** 1 M 2 □ F Days Hours 1271871953 219-62-9035 57 Maryland Director Usual Residence of Decedent iral", or items 23a or 28a-f show Examiner must be notified at 10b. County 10a. State 10c. City, Town or Location 10d. Inside City Limits Director 1 Tes 2 X No Maryland Wicomico Salisbury 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21804 USA Funeral 1848 Saint Lukes Road 12. Was Decedent Ever in U.S. Armed Forces?
1 ☐ Yes 2 🎛 No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. "natural", or 1 Never Married 2 X Married Completed by 1 Yes 2 X No Specify. white 3 Widowed 4 Divorced Year or Dates event, the Medical 15. Decedent's Education 16a Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) marked other than College (1-4 or 5+) Elementary/Seconday (0-12) owner/operator Petroleum Be Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Florance Abbott James N. Culver 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1848 Saint Lukes Rd., Salisbury, MD 21804 Martha Culver/spouse Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State permit. Page 1 a
Department of H
Important: If ite
any injury or ott cemetery, crematory or other place) 1 X Burial 2 Cremation 3 Removal from State Mt.Olive Church 4 Donation 5 Other (Specify) 3/30/2011 Snow Hill, MD 21. Signature of Funeral Service Licer Holloway Funeral Home Professional Association 501 Snow Hill Rd., Salisbury, MD 21804 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Onset and Death Immediate Cause (Final mamous cell carcinoma The Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner MHT 0 Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury that initiated events Examine the burial-transi Due to (or as a consequence of) resulting in death) Last Physician/Medical for use as IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months? Month Pregnant at time of death 1 Yes 2 g Unknown 2 No s been signed by the s g 🗌 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 s autonsy 1 ☐ Yes 2 ☐ No Yes 2 No 25. Was case referred to medical or Attending Physician: funeral director, 26. Place of Death (Check only one) Be 2 No Hospital Other: 1 🗌 Yes မ 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 Residence 6 ☐ Other (Specify) 27. Manner of Deatl 28a. Date of injury 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred (Month, Day, Year) 1 X Natural 5 Pending work? within 24 hours after death.

To the Funeral Director: A completed filled in by the fu 2 🗆 No Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, determined To the Hospital or within 24 hours at To the Funeral D Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 Certifying Nurse Practioner. To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier D0014314 Tell-30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Sorlisbury, Md 21801 P. KLUG. MD. 100 ECONTON STREET, 31. Date filed (Month, Day, Year) 32. Reginar's Signature State Registrar

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DHMH 17 Rev 7/2009

21215-0036

Box 68760

Records,

Division of Vital

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygien® \(\Omega\) For State Registrar Certificate of Death Reg. No. 2. Date of Death 1 Decedent's Name (First Middle | Last) Date Month 3 Time of Death Physician/ Henry Christ Lawrence 2011 :00AM Medical 4a, Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner icomico hu If Under 1 Year If Under 24 Hrs 8. Date of Birth 9. Birthplace (State or Foreign Age (In yrs. last birthday) **Funeral** 1 X M 2 □ F Months Days Min. 161-01-7720 91 Yrs Pennsylvania Director Usual Residence of Decedent 28a-f show 10d. Inside City Limits 10a. State 10h County 10c. City, Town or Location permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho any injury or other traumatic event, the Medical Examiner must be notified at Director 1 X yes 2 No Wicomico Salisbury Maryland 10g. Citizen of What Country? 10e. Street and Numbe 10f. Zip Code 21804 USA Funeral Schumaker Drive, Unit 205 1112 S. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, 11 Marital Status Armed Forces? -AWrence Chris Maryland 21215-0036 Black, White, etc. 1 Never Married 2 X Married þ 1 Yes 2 No Specify. If Vec Give Specify: white 3 Widowed 4 Divorced Year or Dates. Army Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry Decedent's Education (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Carpet Business Owner Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Mildred Nahf David Christ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Shirley Christ/spouse 1112 S. Schumaker Dr., Unit 205, Salisbury, MD 21804 Baltimore. 20b. Place of Disposition (Name of 20c. Location - City or Town, State 20a. Method of Disposition netery, crematory or other place) 1 Burial 2 X Cremation 3 Removal from State 2/29/2011 Salisbury, MD Salisbury Crematory 4 Donation 5 Other (Specify) Signature of Funeral Service License Holloway Funeral Home Professional Association 501 Snow Hill Rd., Salisbury, MD 21804 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line Interval Between Onset and Death Immediate Cause (Final DEMENTUA Physician disease or condition Medical resulting in death) Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of) physician and the burial-transit Cause (Disease or injury that initiated events requires that the death certificate be executed Due to (or as a consequence of): resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 use as t IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy
5 ☐ Other (specify) ___ in the past 12 months? Year Month Day Pregnant at time of death 1 Yes 7 No the 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an To the Hospital or Attending Physician: The law r within 24 hours after death.

To the Funeral Director: After this certificate has b autopsy performed? Yes 2/1 1 Tes Was case referred to medical 26. Place of Death (Check only one, Be examiner? HOSPICR Hospital 2 No Other: 1 Tyes 4 Nursing Home 5 Residence 6 Other (Specify) ဂ္ဂ 1 Inpatient 2 ER/Outpatient 3 IDOA 28a. Date of injury completed filled in by the funeral 28b. Time of 27. Manner of Death 28c. Injury at 28d. Describe how injury occurred Certificate: Natural (Month, Day, Year) injury work? 1 ☐ Yes 2 ☐ No 5 Pending Investigation Accident 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Suicide determined 4 Homicide Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifies Certifying Purse Practioner. To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner. To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 29b. Signature and title of certifier 29c. License number D0058410 03-28-2011 0 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 130 P GHU um 32. Registrar's Signature 31. Date filed (Month, Day Year) State MAR Registrar

Please Type or Print in Black Indelible Ink., 5nşyra All Copies Are Legible.
State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ MARCH 28,2011 **ERMA** GAE CORLEY 5:40P Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death FREDERICK MEMORIAL HOSPITAL FREDERICK FREDERICK If Under 1 Year | If Under 24 Hrs. 8. Date of Birth 7. Age (In vrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Months Days Hours West Virginia 1 🗆 M 2 💢 F **Director** 1922 235-20-5934 Usual Residence of Decedent or 28a-f show notified at 10a. State 10b. County 10c. City, Town or Location filed within 72 hours after death with the Maryland 10d. Inside City Limits Director 1 X Yes 2 No Frederick |Maryland Frederick 10e. Street and Number 10f, Zip Code ò 10g. Citizen of What Country? must be r Funeral United States 21702 355 Montevue Lane, Room 39 tems 2 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) ה''natural", or item fedical Examiner וי 12. Was Decedent Ever in U.S. 14. Race - American Indian Armed Forces?

1 Yes 2 X No Black, White, etc. 1 Never Married 2 Married þ Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 XNo Specify: Specify: Completed 3 X Widowed 4 Divorced White Il Hygiene. I other than "natura vent, the Medical E 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) n and Mental Hygien 7 is marked other the raumatic event, the Hotels Housekeeper Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname, ည Frances Beatrice Carder 27 is marked r traumatic e William Luther Ramage Page 1 and 2 should ment of Health and Me 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3905 Shakespeare Way, Monrovia, Maryland 21770 permit. Page 1 and 2 Department of Health Important: If item 27 any injury or other to once. Robin Castle / Daughter 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other place) 1 XBurial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) 2011 Greenlawn Masonic Cemetery: <u>Clarksburg, West Virgin</u>, OF Uneral Service Licen Keeney and Basford PA Funeral Home 106 East Church Street Frederick. 23a. Part 1. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Onset and Death Physician/ disease or condition Medical resulting in death) Due to (or consequence of): Examiner Sequentially list conditions, Examiner Que to (or as a consequence of, if any, leading to immediate cause. Enter Underlying or Attending Physician: The law requires that the death certificate be executed Cause (Disease or linjury that initiated events and the burial-tran Due to (or as a consequence of): resulting in death) Last attending physician Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: nse 23c. If yes, outcome of pregnancy Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?

1 Yes 2 No Month Day Year the be detached 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 autopsy performed certificate 1 Yes 2 No Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 10 1 🗌 Yes Other: Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) After this funeral 1 Natural Manner of Death 28b. Time of 28c. Injury at Certificate: 28a. Date of injury 28d. Describe how injury occurred (Month, Day, Year) 5 \square Pending work 1 🗌 Yes 2 🗆 No Accident Investigation within 24 hours after deat To the Funeral Director: Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide determined To the Hospital Medical 29a. Certifier Lactifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated, Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 32. Registrar's Signature 31. Date filed (Month. State Registrar

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death ∧ Month Physician/ 1:05 DM 2011 FRANCES INEZ COOPER Medical 4b. City, Town, or Location of Death 4a. Facility Name (if not institution, give street and number) 4c. County of Death **Examiner** Plata La harles Medical Center If Under 1 Year I If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 1-20-1949 9. Birthplace (State or Foreign Country)
MD • **Funeral** Months Director 219-84-1699 62 Usual Residence of Decedent 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location notified at Director LA PLATA 28a-f MD. CHARLES 1X Ves 2 No 10f, Zip Code 10e. Street and Number 10g. Citizen of What Country? the Medical Examiner must be Funeral items 23a 1 HICKORY LANE 20646 U.S.A. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, 11. Marital Status Black, White, etc Armed Force: 1 X Never Married 2 ☐ Married Yes 2X No ō Completed by 1 ☐ Yes 2 XNo Specify: If Yes, Give Year or Dates. Specify: BLACK 3 Divorced 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15 Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) HOUSEKEEPER SELF EMPLOYED 7th and Mental Hygie is marked other Department of Health and Mental Hygi Important: If item 27 is marked othe any injury or other traumatic event, Be filed Baltimore, Maryland 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) ဂ္ WILLIAM HERBERT COOPER LOTTIE MEREDITH Page 1 and 2 should be f ment of Health and Menta ant: If item 27 is marked 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) DORIS HEMSLEY-SISTER HICKORY LANE LA PLATA, MD. 20646 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place)
ST. JOSERH'S CEM. 1X Burial 2 Cremation 3 Removal from State 4-15-11 POMFRET, MD, 4 Donation 5 Other (Specify) M00479 More and Address of Facility 21. Signature of Funeral Service Licensee AYMOND FUNERAL A PLATA, MARYLA 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ Medical resulting in death) Du ato (or as a consequence Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine To the Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or iinjury that initiated events resulting in death) Last and the burial-tran Due to (or as a consequence of): attending physician Physician/Medical Division of Vital Records, P.O. Box 68760 use as IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 1 Live Birth
4 Pregnant a
9 Unknown 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No Month Year Pregnant at time of death 5 Other (specify) be detach signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use of ntribute to the cause of death? ģ 1 🗌 Yes 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an within 24 hours after death.

To the Funeral Director: After this certificate has autopsy page 2 perform 1 ☐ Yes 2 ☐ No director. 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? 10 Hospital: 2 No ı ₩ Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) completed filled in by the funeral 27. Manger of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: work?
1 Yes 2 No 1 Natural 5 Pending Investigation Accident Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Medical Certifying Physician: To the best of my knowledge, death oc ured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investination, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated certifying Nurse Practioner: To the best of my knowledge, path occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check 3 🗆 only one) 29b. Signature and title of certifier 29c. License number 30. Name and add of person who completed cause of death (Item 23a) (Type, Print)

State Registrar

DHMH 17 Rev 7/2009

32. Regis

7C Past Office Rd

11-02663	
Pobert Crawford	

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Robert Crawford	State of Maryland / Department of Health and Mental Hy 1- For State Certificate of Death Registrar	Reg. No.	1 1209								
Physician Medical Examine	n/ 1. Decedent's Name (First, Middle,Last)	2. Date of Death Month Day Year April 7, 2011	3. Time of Death 1036 hrs								
4	4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 25720 Military Road Cascade	4c. County of Death Washington	h								
Funeral Director	5. Social Security Number 5.6 Sex 1 Age (In yrs. last birthday) 5.6 - 44 - 0271 1 Y M 2 F 61 1 Yrs. Months Days Hours Min.	8. Date of Birth(MM/DD/YYYY) 9. Bir May 20, 1949 Co									
any	Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location	1	10d. Inside City Limits								
E	Md. Washington Cascade		1 Yes 2 No								
3a or 28a-l	10e. Street and Number 25720 Military Rd. 10f. Zip Code 21719	10g. Citizen of What Cou U.S./	Α								
ter death with ", or items 2 er must be s	11. Marital Status 1 Never Married 2 Married 12. Was Decedent Ever in U.S. 1 Never Married 2 Married 13. Was Decedent of Hispanic Origin? (Specify Cuban, Mexican, Puerto Full Company		rican Indian, Black, White								
Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho injury or other traumatic event, the Medical Examiner must be notified at once.	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 3 16. Decedent's Usual Occupation (Give kind of working life. DO NOT use retires during most of working life. DO NOT use retires Mail 1 man 17. Father's Name (First, Middle, Last) 18. Mother's Name (Table 1) 18. Mother's Name (Table 2) 18. Mother's Name (Table 3)										
215-00; be filed with ntal Hygiene riked other ti ent, the Mes	17. Father's Name (First, Middle, Last) Marvin L. Crawford 18.Mother's Name (Trevaluation of Trevaluation of	(First, Middle, Maiden Surname) a M. Tatum									
AD 21 2 should and Mer 27 is man matic ev	19a. Informant's Name/Relationship (Type, Print) Judith Elaine Crawford (Wife) 19b. Mailing Address (Street and Number or Ru 25720 Military Rd. Cas	ural Route Number, City or Town, State SCade, Md. 21719	e, Zip Code)								
more, N Pages I and ent of Health int: If item	20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other Specify: 20b. Place of Disposition (Name of cemetery, crematory or other place) Smithsburg Crematory Apr	il 12, 2011 Smithsb									
Balti permit. Departm Imports Injury o	21. Signature of Funeral Service Licensee M01414 J.L. Davis Funeral	Home 12525 Bradb									
Physician // // // // // // // // // // // // //	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or failure. List only one cause on each line.	respiratory arrest, shock, or heart	Approximate Interval Between Onset and Death								
Examiner	Immediate Cause (Final disease or condition resulting in death) a. Intraoral Shotgun Wound Due to (or as a consequence of):		Bodur								
ğ	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause										
d ansit	(Usease or injury that initiated events resulting in death) Last Due to (or as a consequence of):										
50, te be executed yysician and burial - transit	UNPENDED AMENDED O. AMENDED O. AMENDED		1								
Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after cleath. To the Functal Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial - transition of certification: To Be Completed by the Directorian Madical Expending Inc.	23b. Was decedent pregnant in the past 12 months? 1 Live birth 4 Pregnant at time of death 5 Other (Specify)	23d. Date of deliver Month	y Day Year								
that the de ed by the detached f	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.	a divina									
Division of Vital Records, P.O. tal or Attending Physician: The law requires that the state death. The Director: After this certificate has been signed by led in by the funeral director, page 2 should be detach		24a. Was an 24b. Were a	utopsy findings available completion of cause of								
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ion of tending Pheesth. tor: After tithe funeral		28d. Describe how injury occurred Subject shot self									
Divisior To the Hospital or Attend within 24 hours after death To the Funeral Director: completely filled in by the	28e. Place of Injury - At home, farm, street, factory, office building, etc.	28f. Location (Street and Number or R or Town, State) 25720 Military Road, Cascade, MD									
To the Host within 24 hc Completely formal completely formal form	Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and of cone one Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at	due to the cause(s) and manner as sta the time, date and place, and due to tl	ted he cause(s)								
F. With	29b. Signature and title of certifier 29c. License number O.C.M.E. OCM	29d. Date signed (Mo April 8, 2011	onth, Day, Year)								
	30. Name and address of person who completed cause of death (Item 23a) Theodore M. King, Jr., MD. Assistant Medical Examiner 111 Penn Street, Baltimore	, MD 21201									
Stat	ate 31. Date filed (Month, Day, Year) 32. Registrar's Signature										

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 11-02278 Rebecca Lynn Deskins State of Maryland / Department of Health and Mental Hygiene - For State Certificate of Death Reg. No Registrar 1. Decedent's Name (First, Middle,Last) 2. Date of Death 3. Time of Death Physician/ Month Day March 24, 2011 0004 hrs Medical Examiner Rebecca Lynn Deskins 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Calvert Memorial Hospital Calvert 5. Social Security Number If Under 1 Year If Under 24Hrs. 8. Date of 8irth (MM/DD/YYYY) 9. 8irthplace (State or 7. Age (In yrs. last birthday) **Funeral** Foreign California Months Days Hours Director 01/12/1974 611-30-7606 1 M 2 X F 37 Usual Residence of Decedent 10d. Inside City Limits 10a State 10b. County 10c. City, Town or Location 1 Yes 2 X No nr 28a-f shov s 23a nr 28a-f shove e notified at once. Maryland Calvert Lusby Pages I and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygere.
ant: If item 27 is marked other than "natural", ur items 23a nr 28a-f she ur other traumatic event, the Medical Examiner must be notified at once. 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? United States ä 8259 Sycamore Road 20657 11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14, Race - American Indian, 8lack, Armed Forces? If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 Never Married 2 X Married Yes 2 X No 1 Yes 2 No specify: 3 Widowed 4 Divorced If Yes, Give Year Specify: White 쥰 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done 16b. Kind of 8usiness/Industry during most of working life, DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Baltimore, MD 21215-0036 Electric / Gas Co. 12 Meter Reader Com 17. Father's Name (First, Middle, Last) 18.Mother's Name (First, Middle, Maiden Surname) æ Terry L. Clouston Joseph B. Ramos 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) David Daniel Deskins / Spouse 8259 Sycamore Road, Lusby, Maryland 20657 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, 20c. Location - City or Town, State Date crematory or other place) 1 Burial 2 X Cremation 3 Removal from State 03/27/2011 Glen Burnie, Maryland Atlantic Crematory LLC 4 Donation 5 Other Specify permit. 21. Signature of Funeral Service License 22. Name and Address of Facility Rausch Funeral Home, F.A. P.O. Box 600, Lusby, Maryland 20657 Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiec or respiratory arrest, shock, or heart Approximate Interval **Physician** Between Onset and failure. List only one cause on each line /Medical Death a. Cirrhosis of the Liver Immediate Cause (Final disease xaminer or condition resulting in death) Due to (or as a consequence of) Sequentially list conditions. Examiner Due to (or as a consequence of): if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated Due to (or as a consequence of): events resulting in death) Last and The law requires that the death certificate be executed rsician/Medical UNPENDED AMENDED the attending physician ed for use as the burial -Box 68760, IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant in the Live birth Fetal death 3 Ectopic pregnancy Day Year past 12 months? Pregnant at time of death 5 Other (Specify) 1 Yes 2 No 9 Unknown Unknown 된 Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, P.O. <u>á</u> 1 Yes 2 No 3 Probably 4 Unknown Completed 24a. Was an 24b. Were eutopsy findings available prior to completion of cause of autopsy certificate has death? performed? Yes 2 No 1 Yes 2 No or Attending Physician: after death. 26.Place of Death (Check only one) 25. Was case referred to medical Division of Vital Other Nursing Home 5 Residence 6 Other After this 1 Yes 2 No 28a. Date of Injury (Month, Day,Year) 28b. Time of Injury 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred Certification: 1 🗹 Natural 5 Pending 1 Yes 2 No Director: 2 Accident Investigation 28e. Place of Injury - At home, farm, street, factory, office building, etc 28f. Location (Street and Number or Rural Route Number, City 3 Suicide Could not be or Town, State) determined within 24 hours a To the Funeral I __ Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical 2 Wedical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29c. License numbe 29d. Date signed (Month, Day, Year) 29b. Signature and title of certif O.C.M.E. March 24, 2011 40 30. Name and address of person who completed cause of death (Item 23a) Victor Weedn MD JD Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201 31. Date filed (Month, Day, Year 32. Registrar's Signature State arket Registra

DHMH 17 Rev 1/2001 OCME 2006 Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760

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certif nding use a	sician/Med	IF FEMALE: 23b. Was decedent pregnant		23c. If yes, out			7 F-ti						23d. Date of deliv	very	
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To the Hospital or Attending Ph within 24 hours after death. To the Funeral Director: After the completed filled in by the funeral	edical	29a. Certifier 1 X Certi	fvina Ph	vsician: To the b	pest of my kn	owledge, death	occured at	the time	. date and	place, an	d due to the ca	use(s) ar	nd manner as stat	ed.	
e Hos 124 h e Fur eleted	Medi	(Check 2 Medi	cal Exan	niner: On the bas	sis of examina	ation and/or inves	stigation, in	my opinio	on, death o	ccurred at	the time, date	and place	, and due to the cas) and manner as s	ause(s) and ma	nner stated
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death . Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ March 24, Day 2011 12:45 A.M Cecelia DeVere Margaret Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Chesapeake Beach Calvert 2741 Karen Drive Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth Funeral 9. Birthplace (State or Foreign Days Months Hours Min. 1 □ M 2 👿 F New Jersey 0992471942 Director 144-34-5998 68 Usual Residence of Decedent 3a or 28a-f shov t be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 Tes 2 X No Chesapeake Beach MD Calvert 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Completed by Funeral 23a 7 is marked other than "natural", or items 23: traumatic event, the Medical Examiner must l 20732 U.S.A. 2741 Karen Drive Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11 Marital Status 14. Race - American Indian, Armed Forces Black, White, etc. 1 Never Married 2 Married ☐ Yes 2 🕅 No 3altimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify. If Yes, Give 3 X Widowed 4 Divorced Year or Dates white 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) I Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) health care nurse Be 17. Father's Name (First, Middle, Last) Department of Health and Mental H Department of Health and Mental H Important: If item 27 is marked or any injury or other 18. Mother's Name (First, Middle, Maiden Surname) ပ Evelyn Hines С. Walz 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2741 Karen Drive, Chesapeake Beach, MD David S. DeVere, son 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 \square Burial 2 \nearrow Cremation 3 \square Removal from State 4 \square Donation 5 \square Other (Specify). Metropolitan Crematory 03/24/2011 Alexandria, VA 22. Name and Address of Facility Rausch Funeral Home, Signature of Funeral Service Licens 8325 Mt. Harmony Lane, Owings, MD 20736 23a. Part 1. En er the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or hear failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) canco Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Examine Due to (or as a consequence of) burial-transit that initiated events resulting in death) Last Due to (or as a consequence of) attending physician Physician/Medical Box 68760 use as the IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 🔀 No 4 Pregnant 9 Unknown Month Pregnant at time of death 5 Other (specify) Day Year 1 ☐ Yes 2 ☐ Unknown is been signed by the should be detached Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Records, 1 XYes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a, Was an has page 2 performed? Yes 2 this certificate 2 No 1 Tyes To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director; After this certific Division of Vital 25. Was case referred to medical funeral director, Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No ပ္ 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending Investigation 6 Could not be 1 Yes 2 No Accident 2 L. Accident
3 L. Suicide
4 L. Homicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined Medical 29a. Certifier 1 🙎 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifie MD DU059061 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Suite 212 Prince Frederick

DHMH 17 Rev 7/2009

State Registrar 31. Date filed (Month, Day, Year)

P.O. |

32. Registra s Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ DANIELS Year BOBBIE Day 25 320 AM LAYNE MARCH 2011 Medical 4c. County of Death 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** RIVER CHESTER HOSVITAL CHESTERTOWN 5. Social Security Number If Under 1 Year If Under 24 Hrs. 6. Sex 8. Date of Birth 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) **Funeral** 1 □ M 2 🗶 F Days Hours Months Yrs 05<u>/16/1954</u> Director VIRGINIA 235-90-5038 Usual Residence of Decedent 28a-f show 10a. State 10b. County notified at 10c. City, Town or Location 10d. Inside City Limits Director 1 X Yes 2 No CHESTERTOWN MD KENT ō 10e, Street and Numbe 10f. Zip Code 10g. Citizen of What Country? must be I 23a Funeral 123 PHILOSOPHERS TERRACE UNITED STATES 21620 death 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 █ No If Yes, Give Year or Dates. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. ò þ 1 Never Married 2 X Married Baltimore, Maryland 21215-0036 72 hours after 1 ☐ Yes 2 X No Specify: Specify: "natural" Completed 3 Widowed 4 Divorced WHITE the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b, Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) and Mental Hygiene. College (1-4 or 5+) Elementary/Seconday (0-12) NURSING ASSISTANT 10 HEALTH CARE Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည UNKNOWN FRANCES LOUISE BOYD permit. Page 1 and 2 sh.
Department of Health an.
Important: If item 27 is m. any injury or other 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 123 PHILOSOPHERS TERRACE CHESTERTOWN, MD 21620 FRANKLIN DANIELS, SR./HUSBAND 20b. Place of Disposition (Name of 20a. Method of Disposition 20c. Location - City or Town, State cemetery, crematory or other place) 1X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) CHURCH HILL CEMETERY 03/28/2011 CHURCH HILL, MARYLAND of Juneral Service Licer Kicks FELLOWS, HELFENBEIN & NEWNAM FUNERAL 130 SPEER ROAD CHESTERTOWN, MARYLAND 23a. Part 1. Enter the disease, or complid tions that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final NOW - SMALL CARCINOMA Ph sician/ CELL 079 disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner Sequentially list conditions. Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury Due to (or as a consequence of): and I-transit law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): attending physician a for use as the burial-Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: nse 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) in the past 12 months?
1 ☐ Yes 2 🗷 No Day Pregnant at time of death Unknown 9 Unknown s been signed by a should be detact Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 X Probably 4 ☐ Unknown Were autopsy findings available prior to completion of cause of 24a. Was an has autopsy performed? Yes 2 No page Physician: The 1 Yes 2 No this certificate Yes 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner?

1 Yes Hospital: Other: 2. No ျ 1 Npatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred Hospital or Attending 1 X Natural 5 Pending injury work? 1 ☐ Yes 2 ☐ No nours after death.

neral Director: Aft

filled in by the fur М 2 Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number 4 Homicide determined 24 hours Medical 1 🔀 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. within 2 To the I only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) DO071130 MARCH 25, 2011 4 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 21620 St CHESTERTOWN MD 100 BROWN ms JACOSS MD 31. Date filed (Month, Day, 32. Regi rar's Signature State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene. for State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Marc Physician/ 6:50am 2011 Ken Lee Davis, Sr. Medical 4a. Facing and in not institution, give street and number 4b. City, Town, or Location of Death 4c. County of Death **Examiner** a Charles Medical Center If Under 1 Year If Under 8. Date of Birth 9. Birthplace (State or Foreign Social Security Number 7. Age (In yrs. last birthday) **Funeral** Country)GA Feb. 5 Pay 1934 1**X** M 2 □ F Months Davs Hours 77 255 52 8774 **Director** Usual Residence of Decedent or 28a-f show notified at 10b. County 10d. Inside City Limits 10c. City. Town or Location 10a. State Director 1X Yes 2 ☐ No MD Charles Waldorf 10g. Citizen of What Country? 0 10e. Street and Number 10f. Zip Code must be Funeral USA 11080 Weymouth Court #419 20603 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14 Race - American Indian. 11. Marital Status Examiner Armed Forces?

1 Yes 2 No Black, White, etc. or. by 1 Never Married 2 Married filed within 72 hours after SpecifyBlack If Yes, Give Year or Dates 1 Yes 2 XNo Specify: "natural", 3 Widowed 4 Divorced Completed Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life, DO NOT use retired) Elementary/Seconday (0-12) 8th College (1-4 or 5+) the Machine Operator Private alth and Mental Hygien
27 is marked other to
traumatic event, the Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ၉ Leroy Davis Athleena Olive 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health a Important: If item 27 is any injury or other tra Marie Davis/ Wife 11080 Weymouth Ct.#419 Waldorf,MD 20603 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1X Burial 2 ☐ Cremation 3 ☐ Removal from State Heritage Mem.Cem. 4/4/2011 4 Donation 5 Other (Specify) Waldorf, MD 21. Signature of Funeral Service Lice 22. Name and Address of FacilitBriscoe-Tonic Funeral Home 2294 Old Washington Rd.Waldorf, MD 20601 23a. Port 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. et ind Darlin Immediate Cause (Final hypotension Ph sician/ disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner ducardia Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examiner Due to (or as a consequence of): sician and burial-transit 15Chemu Cause (Disease or liniury that initiated events resulting in death) Last attending physician for use as the buria Physician/Medical that the death certificate be 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months?
1 ☐ Yes 2 ☐ No Month Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? sate has been signed page 2 should be de by 1 ☐ Yes 2 ☐ No 3 💆 Probably 4 ☐ Unknown recent sepsis Records, Completed Acute on Commi Renal Failure 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an performed. Yes 2 L No oahetc 1 Yes 2 No 25. Was case referred to medical of Vital Hospital or Attending Physician: director, 26. Place of Death (Check only one) Be examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital 1 Yes 2 Wo 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA ၉ this funeral 27. Magner of Death 28b. Time of 28a. Date of injury 28c. Injury at work? Certificate: 28d. Describe how injury occurred (Month, Day, Year) 5 Pending 1 💋 Natural Division 1 Yes 2 No within 24 hours after death.

To the Funeral Director: Air completed filled in by the fu Accident Investigation 3 ☐ Suicide 4 ☐ Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined Medical Dertifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner. On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check Cultifying Nogel Programme To best of my knowledge, death 29b. Signature 2011 completed cause of death (Item 23a) (Type, Print) Name and ddress of person wh, La Plata MD 2064 31. Date filed (Month, Day, Year) State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day 2011 Dorsey Physician/ Katie Suzanne 4:09 p M March 24, Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Indian Head Charles 20 Glymont Rd. If Under 1 Year If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Days May 18, 1978 1 □ M 2 😾 F Hours Country) Virginia 215-17-6186 32 **Director** Usual Residence of Decedent 28a-f show 10c. City, Town or Location 10d. Inside City Limits iral", or items 23a or 28a-f sho Examiner must be notified at Director Indian Head MD Charles 1 🗆 Yes 2 😾 No 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code 20640 20 Glymont Rd. Funeral "natural", or items filed within 72 hours after death 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11, Marital Status 14 Race - American Indian Armed Forces? Black, White, etc. 1 Never Married 2 Married þ Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify: White If Yes, Give Year or Dates 3 Widowed 4 Divorced Completed injury or other traumatic event, the Medical 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) permit. Page 1 and 2 should be filed within 72 Department of Health and Mental Hygiene. Important: If item 27 is marked other than ' Elementary/Seconday (0-12) College (1-4 or 5+) Middle School Teacher Education Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) John Horace Murphy Betty Jane Killen 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) $20\,$ Glymont Road, Indian Head, MD $20640\,$ 19a. Informant's Name/Relationship (Type, Print) Theodore Dorsey/Husband 20b. Place of Disposition (Name of cemetery, crematory or other) 20c. Location - City or Town, State Brinsfield-Echols Crem.4/1/2011 Charlotte Hall, MD 4 Donation 5 Other (Specify) M00945 e of Funeral Service Licensee 22 AREHART ECHOLS FUNERAL HOME, P.A. a Mary's Ave. La Plata,MD 23a. Part 1. Enter the disease, or complications the shock, or heart failure. List only one cause or at caused the death. Do not enter the mode of dying such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition Physician/ Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of) physician and the burial-transit requires that the death certificate be executed Cause (Disease or iinjury that initiated events Due to (or as a consequence of) resulting in death) Last Physician/Medical Box 68760 attending p IF FEMALE 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 3 Ectopic pregnancy 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? Month Dav Year 5 Other (specify) Pregnant at time of death Yes 2 No ed by the a g Unknown 9 Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. signed k 23e. Did tobacco use contribute to the cause of death? þ Records, 1 Yes 2 No 3 ☐ Probably 4 ☐ Unknown Completed should I 24b. Were autopsy findings available prior to completion of cause of 24a. Was an the Hospital or Attending Physician: The law in 24 hours after death. The Funeral Director: After this certificate has tripleted filled in by the funeral director, page 2 s autopsy performed death? 1 🗌 Yes 2 🗌 No 25. Was case referred to medical 26. Place of Death (Check only one) **Division of Vital** Be examiner? 2 No Hospital: Other: 1 Yes 2 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify, 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred Natural injury 5 Pending 1 Yes 2 No Accident Investigation 3 ☐ Suicide 4 ☐ Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State To the Hospital o within 24 hours aff To the Funeral Dia Medical 29a. Certifier retifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. ☐ Medical Examiner: On the basis of exami
☐ Certifying Nurse Practioner: To the nination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one 29b. Signatur and title of certifier 29d. Date signed (Month. who completed cause of death (Item 23a) (Type, Print)

DHMH 17 Rev 7/2009

State Registrar 31. Date filed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiener for State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Physician/ 333 W Derrickson sannen Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Wicomic ecional Medical Cente Date of Birth (Month, Day, Year) 3-30-1943 Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday **Funeral** Min. 1 **X**M 2 □ F Months Davs Hours Director Usual Residence of Decedent ms 23a or 28a-f show must be notified at 10d. Inside City Limits 10b. County 10a. State 10c. City, Town or Location filed within 72 hours after death with the Maryland Director 1 Yes 2 No VΑ Accomac hincoteague 10g. Citizen of What Country? 10e. Street and Number Funeral 23336 U.S.A 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, 11. Marital Status Armed Forces 5 þ 1 Never Married 2 Married Yes 2 X No Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 Yes 2 No Specify: White "natural", Completed 3 Widowed 4 Divorced the Medical 16b. Kind of Business Industry 15. Decedent's Education 16a. Decedent's Usual Occupation (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Horntown ረአትዕር permit. Page 1 and 2 should be filed wit Department of Health and Mental Hygie Important: If item 27 is marked other any injury or other traumatic event, tt Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) 2 Dernckson Harold Gannon mma 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2333L Chi<u>ncoteaque</u> Ann 4343 .VA Derrickson 20c. Location - City or Town, State 20b. Place of Disposition (Name of 20a. Method of Disposition Date Department of Important: If it any injury or o cemetery, crematory or other place) 1 🛣 Burial 2 🗆 Cremation 3 🗆 Removal from State Chincoteague Mechanics 2011 4 ☐ Donation 5 ☐ Other (Specify) Cometery Chincoteogue, UA 2336 21. Signature of Funeral Service Licensee 22. Name and Address of Facility amanda Church St Homz inc 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Coloroscula ARTERIOSCLEROTIC Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of). **Examiner** Sequentially list conditions, if any, leading to minimize cause. Enter Underlying Cause (Disease or iinjury Due to for as a consequency of: Examine use as the burial-transit Hospital or Attending Physician: The law requires that the death certificate be executed and that initiated events resulting in death) Last Due to (or as a consequence of) physician Physician/Medical Division of Vital Records, P.O. Box 68760 the attending IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death
4 Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months? Year jo Month Day Pregnant at time of death signed by the a g 🗌 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Diabetes mellitus 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown HYPETINSION 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy this certificate has page, performe 1 🗌 Yes 2 🗎 No Yes 2 No funeral director, Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital Other: 2 No 1 Tes 1 Inpatient 2 K ER/Outpatient 3 IDOA မှ 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Certificate: 28c. Injury at within 24 hours after death.

To the Funeral Director: After completed filled in by the funer Natural 5 Pending injury work? 1 ☐ Yes Accident 2 🗌 No Investigation 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29d. Date signed (Month, Day, Year) 29b. Signature and title of 2011 30. Name and address of person who completed gause of death (Item 23a) (Type, Print) ocomoke 1 enth egistrar's Signature State Registrar

Registrar DHMH 17 Rev 7/2009

State

Box 68760

P.O.

Records,

of Vital

Division

6602 CHURCH HILL ROAD CHESTERTOWN, MARYLAND 21620

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DELBOY

_M.D.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar item #26,per physicians, 3/31/11 E T WCHD Reg. No. Amended 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month 03 Physician/ 2:40 a M Eleanore Dexter Elligson 2011 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** 34055 Clearfield Drive Pocomoke Somerset Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign 6. Sex 7. Age (In vrs. last birthday) **Funeral** 1 □ M 2**X** F Days Months Hours Min Mary land 2/24/1924 87 Director 212-22-2390 Usual Residence of Decedent items 23a or 28a-f show ner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits filed within 72 hours after death with the Maryland Director 1 X Yes 2 No MD Worcester Pocomoke 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 215 Tenth Street, 21851 Apt. 101 USA 12. Was Decedent Ever in U.S. Armed Forces?
1 ☐ Yes 2 XNo
If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Examiner Black, White, etc. , or þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 XNo Specify. Specify: "natural" Completed 3X Widowed 4 ☐ Divorced white Year or Dates the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) it. Page 1 and 2 should be line, ... artment of Health and Mental Hygiene. ... if item 27 is marked other than want, the M other than Elementary/Seconday (0-12) College (1-4 or 5+) 12 Homemaker Domestic Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ James Dexter Elsie Lavina Dinsmore 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Paul Elligson (son) 34055 Clearfield Drive, Pocomoke, MD 21851 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State permit. Page 1 a Department of H Important: If ite any injury or ot 1 🗶 Burial 2 🗌 Cremation 3 🗌 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Middletown Cemetery 4/4/2011 Freeland, Maryland 22. Name and Address of Facility
Holloway Funeral Home, Professional Association
107 Vine Street, Pocomoke, MD 21851 Signature of Fune al Service Licensee 21. Min 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between shock, or heart failure. List only one cause on each line Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) Q Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine The law requires that the death certificate be executed burial-transi Cause (Disease or linjury that initiated events resulting in death) Last Due to (or as a consequence of): attending physiciar Physician/Medical Box 68760 as IF FEMALE: use 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregna 5 Other (specify) Ectopic pregnancy in the past 12 months?

1 Yes 2 No been signed by the atte should be detached for Day Month Year Pregnant at time of death 9 Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 2 No 3 Probably 4 Unknown Records, 1 Yes Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performe 2 🗌 No 1 Yes To the Hospital or Attending Physician: 1 within 24 hours after death.

To the Funeral Director: After this certifica within 24 hours after death.

To the Funeral Director: After this certific completed filled in by the funeral director, 25. Was case referred to medical of Vital Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Besidence 6X Other (Specify Son's 10 1 🗌 Yes 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Residence 28c. Injury at Manger of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28d. Describe how injury occurred Natural Accident 5 Pending work? Division 1 🗌 Yes 2 No 2 ☐ Accident
3 ☐ Suicide
4 ☐ Homicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifier (Check 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29d; Date signed (Month, Day, Year)

Registrar

DHMH 17 Rev 7/2009

State

naky

31. Date filed (Month

32. Registrar's Signature

oconolle ms

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

6

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No . Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ ^D2011 April 6. Daniel Leo Esworthy, Jr. 12:30 pм Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death Kline Hospice House Mount Airy Frederick 5. Social Security Number If Under 1 Year If Under 24 Hrs. **Funeral** 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign 1 ⊈M 2 □ F Days Jan 9, Year) 922 Maryland 219-14-**7**695 89 Director Usual Residence of Decedent 28a-f show nit, Page 1 and 2 should be filed within 72 hours after death with the Maryland artment of Heatth and Mental Hygiene. ortant: If item 27 is marked other than "natural", or items 23a or 28a-f shoorlant: or other traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director Maryland Frederick Frederick 1 XYes 2 ☐ No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 306 Center Street 21701 U.S.A. 12. Was Decedent Ever in U.S. Armed Forces? 1½ Yes 2 ☐ No If Yes, Give 9.44-1946 Year or Dates. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian Black, White, etc. δ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: White Completed 3 ₩ Widowed 4 □ Divorced Specify: 15. Decedent's Education 16a, Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired)

Manager/Supervisor (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Railroad Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Daniel Leo Esworthy, Sr. Hattie Marie Wilson 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 306 Center Street, Frederick, MD 21701 19a. Informant's Name/Relationship (Type, Print) Donna E. Porter, daughter 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 🕅 Burial 2 🗆 Cremation 3 🗆 Removal from State Mount Olivet Cem. permit, Page
Department o
Important: If
any Injury or
once, Apr 11, 2011 Frederick, MD 4 Donation 5 Other (Specify) 21. Sig lature of Funeral Service Lic Reeney and Bastord PA Funeral Home M00706 East Church St., Frederick, MD 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions. Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury Due to (or as a consequence of) Hospital or Attending Physician: The law requires that the death certificate be executed ending physician and use as the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Division of Vital Records, P.O. Box 68760 cate has been signed by the attending I page 2 should be detached for use as IF FEMALE: yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ Live Birth 2 Fetal death in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day Year Pregnant at time of death 1 ☐ Yes ≥ ☐ 9 ☐ Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24 hours after death.
e Funeral Director. After this certificate has been a funeral director. After the funeral director, page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an performed? 1 Yes 2 🗆 No 2 🗆 N 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 2 No 1 🗌 Yes မ 1 Inpatient 2 ER/Outpatient 3 DOA Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending work Accident Investigation 1 ☐ Yes 2 ☐ No Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check within 2 3 🗌 Certifying Jurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certific 29c. License number 29d. Date signed (Month, Day, Year) 30. Name and address of person who co npleted cause of death (Item 23a) (Type, Print) 32. Registrar's Signature 31. Date filed (Month, Day, Year) State APR

DHMH 17 Rev 7/2009

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			For State	State of Maryla		artment of Health			6011	12102		
			Registrar Decedent's Name (First, Middle, Landson Company)	ast)		Timoate of Beat		Date of Death	j. No.	3. Time of Death		
п	Physici			Fisher			N	Month March 2	Day Year 24 2011	12:00P M		
	/Medic Examin		4a. Facility Name (If not institution, gi	ve street and number)		4b. City, Town, or Locatio			4c. County of Dea			
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	Funeral			1 NOT IN THE	rs. last birthday)	If Under 1 Year If Und Months Days Hours		Date of Birth (Month, Day, Y	(ear) 9. Bir	thplace (State or Foreign ountry)		
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	and and		Usual Residence of Decedent 10a. State 10b. County	10c.	City, Town or Lo	ocation				10d. Inside City Limits		
	danyl daho	ō	Md. Monts	gomery	Silve	er Spring				1 ☐ Yes 2 🕦 No		
	r 28a	Funerai Director	10e. Street and Number			10f. Zip Code		100	0g. Citizen of What Country?			
	h with	ai Di	2909 Norbeck Roa	ad		20906			United States			
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9	or It		1 Never Married 2 Married	1 ☐ Yes 2 🛣 No If Yes, Give		1 ☐ Yes 2 🕱 No Speci			Specify: Wh			
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Maryland 21215-0036	2 8 8 2		19a. Informant's Name/Relationship			ng Address (Street and Nun			-			
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<u>=</u>	it. Partmer		* 4 □ Donation 5 □ Other (Spec 21. Signature of Funeral Service Light			Memorial Pk.			Olney,	, Md.		
Ba	permit. Departn Imports any inju		Roy W. B	au		2. Name and Address of Fac Muriel H. Ba: P. O. Box 50	rber Fu 038. La	meral H	Home 111e, Md.	20882		
		-	23a. Part1. Enter the disease, or con shock, or heart failure. List only	mplications that caused the d						Approximate Interval Between		
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	/Medical		resulting in death)	Due to (or as a cons								
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Вох	eath certific attending p	n/M	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome of pre 1 ☐ Live birth 2 ☐ F		⊒Ectopic pregnancy			23d. Date of de			
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	Thate page							1 ☐ Yes 2	☑ No 1 ☐ Ye	s 2 No		
Vita	ysician: The is certificate hadirector, page	Be	25. Was case referred to medical examiner?	Hospital:		Othor		Check only one				
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Division of	Attander death	ertification;	3 Suicide 6 Could not determine			reet, factory, office	28	f. Location (Str. City or Town,	eet and Number or F State)	Rural Route Number,		
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	To the Hospital or Attanwithin 24 hours after deating the Funaral Director: completely filled in by the	Medical	(Check only 2 Medical Ex	Physician: To the best of my aminer: On the basis of exam								
	the thin 2 that mplet	Med	29b. Signature and title of gertifier	and manner stated.		29c. License numbe	er	29	d. Date signed (Mor	nth, Day, Year)		
	Z 2 8			XVI	MI)	D 3845			March 25			
	10		30. Name and address of person wh	o completed cause of death ((Item 23a) (Type							
	ω		Nakul Goyal, M			onal Dr., #21	1, Silv	ver Spr	ing, Md.	20906		
	Sta		31. Date filed (Month, Day, Year)	32. Riegistrar's Si	ignature	backer						
	Registi	ar	US MAR	GUII JOHNSON	10. 19	D. O.A. do.						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month MELISSA LU FINLEY March 2011 12:05a Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death FREDERICK MEMORIAL HOSPITAL FREDERICK FREDERICK Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth Date of bill. (Month, Day, 6. Sex 7. Age (In vrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Days Hours 1 🗆 M 2 🕱 F New York Director 220-06-6198 47 Nov. T963 Usual Residence of Decedent 28a-f show 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits the Maryland must be notified at Director 1 ☐ Yes 2 No Maryland Frederick Mt. Airy 5 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral or items 23a 5807 Western View Place 21771 United States be filed within 72 hours after death 12. Was Decedent Ever in U.S Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Examiner Completed by 1 Never Married 2 Married 2 🔀 No Yes Yes Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify. "natural", 3 Widowed 4 X Divorced Year or Dates White injury or other traumatic event, the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) d Mental Hygiene. marked other than Elementary/Seconday (0-12) College (1-4 or 5+) 10 None None Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Department of Heath and 2 should be Department of Heath and Menta Important. If item 27 is marked, any injury or other traumair. 2 Richard A. Wood Dorene L. O'Brien 19a, Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Kimberly Shriver/ Sister 5807 Western View Place, Mt. Airy, Maryland 21771 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place) 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State 4 Donation 5 Other (Specify) Stauffer Crematory Inc.3/29/11 Frederick, Maryland. 22. Name and Address of Facility Stauffer Funeral Homes 1621 Opossumtown Pike, 21. Signature of Ineral Servin P. A. Frederick, Maryland 21702 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Pnysician/ mountar 0 one 117 disease or condition Medical resulting in death) **Examiner** noniz Sequentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury that initiated events Due to (or as a consequence of): and Due to (or as a consequence of) resulting in death) Last burialphysician Physician/Medical that the death certificate be Division of Vital Records, P.O. Box 68760 the ! attending pl for use as t IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) in the past 12 months? Pregnant at time of death 2 No the 8 g Unknown g Unknown as been signed by the should be detached Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by or Attending Physician: The law requires 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a, Was an cate has b autopsy performe Yes 2 No this certificate 1 ☐ Yes 2 ☐ No 25. Was case referred to medical funeral director, Be 26. Place of Death (Check only one) examiner? 1 Yes Hospita Other: 2 🗌 No ၉ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify) ithin 24 hours after occur.

o the Funeral Director: After th 27. Manner of Death Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? 1 ☐ Yes 2 ☐ No Certificate: 28d. Describe how injury occurred 1 X Natural 5 Pending injury Accident Investigation 3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Hospital Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. To the 3 🗆 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. within 7 29b. Signature and title of certifie 29d. Date signed (Month, Day, Year) 2011 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Hee Nam Mulena 400 MD 32. Registrar's Signature 29 State ack

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Lindy V. Foster Month 03/29/2011 Year 3:00 Medical 4a. Facility Name (if not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner 55 Walnut Creek Road Huntingtown Calvert . Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Days Hours Min. 11/16/1928 216-22-1160 82 Director Usual Residence of Decedent or 28a-f show notified at permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked of other than "natural", or items 23a or 28a-f sho any injury or other traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director MD 1 Yes 2 TNo Calvert Huntingtown 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 55 Walnut Creek Road 20639 U.S.A. 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 🕱 No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status 14. Race - American Indian, Black, White, etc. ð 1 Never Married 2 Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 🙀 No Specify: Specify: Completed 3 XWidowed 4 Divorced White 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Mechanic Golf Course Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ဂ္ Lillian White Charles Foster 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 55 Walnut Creek Road, Huntingtown, MD 20639 Brenda Rountree/Daughter 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other place) 1 X Burial 2 Cremation 3 Removal from State Southern Mem. Gardens 04/04/2011 Dunkirk, MD 4 Donation 5 Other (Specify) 22. Name and Address of FacilityLee Funeral Home Calvert, 8125 Southern Md Blvd., Owings, MD 20736 21. Sign thre of Fundal Service Licensee P.A. Lisa M. Mounts 8125 Southern Md Blvd., Owings, 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Onset and Death Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate course Enter Underlying Examiner Due to (or as a consequence of): To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit Cause (Disease or iinjury After this certificate has been signed by the attending physician and funeral director, page 2 should be detached for use as the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of): Completed by Physician/Medical Division of Vital Records, P.O. Box 68760 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No 5 Other (specify) Month Dav Year 4 Pregnant : 9 Unknown Pregnant at time of death Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 💆 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an performed? Yes 2 No 2 No 1 Yes Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: Certificate: To 2 🗌 No 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) Manner of Death 28b. Time of 28c. Injury at work? 1 ☐ Yes 2 ☐ No 28d. Describe how injury occurred injury 1 Natural 5 Pending Investigation Accident 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 3 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check To the l within 2 To the l only one) 29b. Signature and title of certifi 29c. License number 29d. Date signed (Month, Day, Year)

Registrar

DHMH 17 Rev 7/2009

State

LRW

Solomons Island Rd Huntingtown MD 20639

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

24/7

32. Registra s Signature

Brad

31. Date filed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death 2. Date of Death March 28, Day 2011 Physician/ 10:17 Рм Doris E. Friend Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Grantsville Garrett Goodwill Mennonite Home If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign Social Security Number **Funeral** 6. Sex Age (In yrs. last birthday) Hours (Month, Day, 1 🗆 M 2 🕱 F Days 183-44-9301 Yrs Pennsylvania Director 88 Dec. Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho any injury or other traumatic event, the Medical Examiner must be notified at any injury or other traumatic event, the Medical Examiner must be notified at 10b. County 10d. Inside City Limits 10a. State 10c. City, Town or Location Director ral", or items 23a or 28a-f s Examiner must be notified 1 X Yes 2 No Friendsville MD Garrett 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21531 USA 113 Bear Creek Ct. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 🛣 No If Yes, Give þ 1 ☐ Yes 2 🔀 No Specify: Completed Specify: 3 Widowed 4 X Divorced White Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b, Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Own Home Homemaker Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည John Spear Izetta Savage 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 7826 Old Hollow Lane, Ellicott City, MD Nola A. Shiller/Daughter 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 🔀 Burial 2 🗆 Cremation 3 🗆 Removal from State Manchester Luth. Cem. April 2, 2011 Manchester, PA 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Newman Funeral Homes, P.A. 21. Signature of Juneral Service P.O. Box 275, Grantsville, MD 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or beart failure. List only one cause on each line. Approximate Interval Between O et and Death Immediate Cause (Final disease or condition Physician/ Medical resulting in death) Due to (or as a consequence of f) **Examiner** aenocasciNoma Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of): the burial-transit Cause (Disease or iinjury that initiated events resulting in death) Last Due to (or as a consequence of): physician Physician/Medical as IF FEMALE: asn yes, outcome of pregnancy
Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy signed by the atte in the past 12 months?
1 Yes 2 No Month Day Year 5 Other (specify) Pregnant at time of death 9 Unknow Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? ģ 1 Yes 2 No 3 Probably 4 Unknown Completed page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an (Oronary has autopsy performe Ne uteri 2 🗌 No 1 Yes Yes 25. Was case rred to medical 26. Place of Death (Check only one) Be examiner? Other: 1 🗌 Yes 2 No မ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) After this the funeral 27. Manner of Dea h 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred Natural Acciden 5 Pending work

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To the Funeral Directo

completed filled in by th

Maryland 21215-0036

Baltimore,

State Registrar

Medical

Accident

Suicide

4 Homicide

only one

29a. Certifier (Check

Investigation 6 Could not be

e and title of certifier

determined

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

strar's Signature

an of person who completed cause of death (Item 23a) (Type, Print) 2 🗌 No

1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

28f. Location (Street and Number or Rural Route Number, City or Town, State)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day 1 Physician/ Month 3 Mary Teresa Gillespie-Miles 8:00PM M Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death Talbot Hospice and Care Center Easton Talbot 7. Age (In yrs. last birthday) 70 yrs 5. Social Secunty Number If Under 1 Year If Under 24 Hrs. 6. Sex 9. Birthplace (State or Foreign **Funeral** 8. Date of Birth 1 🗆 M 2 🔀 F Days Month, Day, Year) / 18/1940 New York 094-32-4434 Director Usual Residence of Decedent 3a or 28a-f show be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits **Funeral Director** MD Talbot Tilghman 1 Yes 2X No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ms 23a must be 21712 Camper Circle 21671 USA Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian, Armed Forces?

1 Yes 2 No
If Yes, Give Black, White, etc. ò ģ 1 Never Married 2 X Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: "natural" Completed White 3 Divorced 4 Divorced Year or Dates dical 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) than Elementary/Seconday (0-12) College (1-4 or 5+) **5** + the Doctor Psychology other Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) and Mental ပ Patrick Gillespie Bridget O'Gara 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Health tem 27 John McNally-Son 19050 Mountain Spring Lane Leesburg VA 20175 or other 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 XBurial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Sacred Heart 3/5/2011 Winchester VA 21. Signature of Funeral Service Licensee Hall Funeral Home, 896 Purcellville, VA Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only see cause on each line. Immediate Cause (Final Physician/ 6/90 disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Examine Due to (or as a consequence of) sician and burial-transit that initiated events resulting in death) Last Due to (or as a consequence of) attending physician for use as the buria Completed by Physician/Medical Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death
4 Pregnant at time of death
9 Unknown 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 mont Month 5 Other (specify) Day Year been signed by the should be detached 9 Unknown P.O. I Part II. **Other signific**an<mark>t conditions</mark> contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, 2 No 3 Probably 4 Unknown 1 Yes 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy To the Hospital or Attending Physician: The I within 24 hours after death.

To the Funeral Director: After this certificate h completed filled in by the funeral director, page performed 1 Tes 2 No **Division of Vital** 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4XX ursing Home 5 Residence 6 Other (Specify) ဂ္ 1 Yes 2K No 1 hpatient 2 ER/Outpatient 3 DOA Certificate: 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending 1 Yes Accident Suicide Investigation Could not be 4 Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) Medical Descriping Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examíner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29d. Date signed (Month Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar
DHMH 17 Rev 7/2009

State

31. Date filed (Month, Day, Year)

strar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiener Certificate of Death Reg. No. 3. Time of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** Month 5: 10 AM 2011 John J. Gibbs /Medical 4c. County of Dealh 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner St. Catherines Nursing Home Emmitsburg Frederick If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** Days Months Min. 1⊠M 2□ F Yrs. Director 73 Dec.21,1937 New York 577-52-2079 Usual Residence of Decedent with the Marylend 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits or 28a-f show th and Mental Hygiene. 7 is marked other than "naturel", or Itema 23s or 28s-1 shov traumatic event, the Medical Examinar must be notified at 1 ☐ Yes 2 No Maryland Frederick Woodsboro Direct 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 10 Rosewood Court # 207 21798 United States Peges 1 and 2 should be filed within 72 hours efter death Funeral 12. Was Decedent Ever in U.S. Armed Forces? Race - American Indian, Black, White, etc. 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ Never Married 2X Married 1 ⊠Yes 2 □ No
If Yes, Give
Year or Dates: Vietnam Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Specify: þ 3 ☐ Widowed 4 ☐ Divorced White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 5+ U. S. Army Chemist 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) ပ Donald Clyde Gibbs Mary Loretta McBride 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Peges 1 and 2 s Department of Health ar Important: if item 27 is eny injury or other trau 10 Rosewood Court # 207, Woodsboro MD 21798 Claryce Jane Gibbs/ Wife 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, Slate 20a. Method of Disposition UNKNOWN 1 Burial 2 □ Cremation 3 □ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Arlington, Virginia. Arlington National Cemetery 21. Signature of Fundal Service License ^{22. Name and Address of Facility} Stauffer Funeral Homes P. A. 1621 Opossumtown Pike, Frederick,Maryland 21702 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final enjord **Physician** ionto disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that left too are on the cause). Due to (or as a consequence of) Examine transit Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events resulting in death) Last and Due to (or as a consequence of) attending physicien are for use as the burial-Division of Vital Records, P.O. Box 68760 Physician/Medical IF FEMALE 23c. If yes, oulcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 ☐Live birth 2 ☐ Fetal death 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Year Month 4☐Pregnant al time of death 5 Other (specify) been signed by the should be detached 9 Unknown 9 Unknown Part I. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Completed 24a. Was an autopsy performed? 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No certificate has t irector, page 2 s 1 Yes 25 No : After this certification funeral director, Be 25. Was case referred to medical 26. Place of Death | Check only one) Hospital: 1 ☐ Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 2 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 28c. Injury al Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Certification: 1 Natural 5 ☐ Pending 1 ☐ Yes 2 ☐ No death. 2 Accident investigation Director: / 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) within 24 hours efter d To the Funerel Direct completely filled in by I 4 | Homicide 29a. Certifier 🔀 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner states. (Check only one) 29b. Signature and title of certifier 29d. Date signed (Mpnth, Day, Year) 10018705 Name and address of person who completed cause of death (Item 23a) (Type, Print) Emmitsburg MM s. seton 310 Han Carroll 15 + 1 VA 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar MAR 3

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ March Day 2011 GREMILLION G 8:41 A. GARDNER 25, Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Frederick Frederick 5825 Butterfly Lane 9. Birthplace (State or Foreign Country) Pennsylvania 5. Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth 7. Age (In yrs. last birthday) **Funeral** (Month, Day, Year)
July 22, Days 1 🛛 M 2 🗆 F Months Hours **Director** 94 277-14-0411 Usual Residence of Decedent and 2 should be filed within 72 hours after death with the Maryland Health and Mental Hygiene. Health and Mental Hygiene. To it marked outher than "natural", or items 23a or 28a-f show ther traunatic event, the Medical Examiner must be notifiled at 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location Director 1 X Yes 2 □ No Frederick Maryland Frederick 10g. Citizen of What Country? 10e. Street and Number Funeral 21703 United States 5825 Butterfly Lane Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, 11. Marital Status Armed Forces?
1 X Yes 2 □ No WWII
If Yes, Give Black, White, etc. ģ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: 3 ☐ Widowed 4 ☐ Divorced White Completed Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) 5+ US Government Microbiologist Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Mary Alice Gray Leonce V. Gremillion 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 240 Woodland Dr., McConnellsburg, PA 17233 Susan Rhoderick / Daughter nit. Page 1 and 2 artment of Healt crtant: If item 2 injury or other 20a. Method of Disposition
1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 3/28/2011 4 ☐ Donation 5 ☐ Other (Specify) Stauffer Crematory Frederick, Maryland permit.
Depertri
Importa
any nju 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Stauffer Funeral Home 1621 Opossumtown Pike, Frederick, MD 21702 Part 1. Enter the dillead, or complications that clused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, and, or heart fail. It is only one cause on each line. Interval Between Onset and Death Immediate Cause (Final disease or condition Physician/ 11100 Medical resulting in death) Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examiner Due to (or as a consequence of) the attending physician and hed for use as the burial-transit Cause (Disease or iinjury that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical To the Hospital or Attending Physician: The law requires that the death certificate be within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physicis Division of Vital Records, P.O. Box 68760 IF FEMALE: 23d. Date of delivery 23b. Was decedent pregnant Live Birth 2 Fetal death 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Month Pregnant at time of death 5 Other (specify) 9 Unknown has been signed by le 2 should be detac Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? þ 2 No 3 ☐ Probably 4 ☐ Unknown 1 Tes Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed ☐ Yes 2 ☐ No 26. Place of Death (Check only one) completed filled in by the funeral director, 25. Was case referred to medical Certificate: To Be examiner? Other: 1 🗌 Yes 4 ☐ Nursing Home 5X Residence 6 ☐ Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA 28c. Injury at work? 28a. Date of injury (Month, Day, Year) 28b. Time of 27. Manner of Death 28d. Describe how injury occurred injury 5 \square Pending Natural 1 ☐ Yes 2 ☐ No Investigation Accident Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) ☐ Suiciue ☐ Homicide 28f. Location (Street and Number or Rural Route Number, determined City or Town, State Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifie 29c. License number

10+1

State Registrar 30. Name a

31. Date filed (Mo.

ed cause of death (Item 28a) (Type

Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) **Physician** 2011 9:20 AM March 26 James Boyd Gott, Sr /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner Calvert Prince Frederick Calvert Memorial Hospital If Under 1 Year | If Under 24 Hrs Date of Birth (Month, Day, Year) April 19, 1921 9. Birthplace (State or Foreign 5. Social Security Number 6. Sex 7. Age (In vrs. last birthday) **Funeral** Months Days Hours Min. 1 X M 2 □ F Maryland 89 579-18-9759 Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a State 10b. County show 7 is marked other than "natural", or items 23a or 28a-f shov traumatic event, the Medical Evaminatious be notified at 1 ☐Yes 2XXNo Director Calvert Prince Frederick Maryland 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number United States 20678 35 Gray Inn Court Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 MYes 2 □ No If Yes, Give Year or Dates: 14. Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 72 hours after 1 ☐ Never Married 2 🗓 Married 1 ☐ Yes 21/2No Specify: White 1945-45 Specify: <u>≨</u> 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Board of Education Supervisor 12 should be filed w h and Mental Hygies 7 Is marked other th 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Sadie Virginia Rawlings Milton Boyd Gott 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) permit. Pages 1 and 2 st Department of Health an Important: If item 27 Is r any injury or other traur 35 Gray Inn Court, Prince Frederick, Maryland 20678 Evelyn LeJeune Gott / Wife 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 Marial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 04/01/2011 Prince Frederick, Maryland Wesley Cemetery 22. Name and Address of Facility 21. Signature of Funeral Service Licensee Rausch Funeral Home, P.A. 4405 Broomes Island Road, Port Republic, Maryland 20676 MO1206 Kyle S. Simons 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) ARTERY DISEASE CORONARY Physician /Medical Due to (or as a consequence of): Examiner STROKE Sequentially list conditions Due to for as a consequence of Examine cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last DISCASE be executed PARKINSON and burial-trar Due to (or as a consequence of): attending physician for use as the buria Physician/Medical Hospital or Attending Physician: The law requires that the death certificate IF FEMALE: If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day Year in the past 12 months? 1 ☐ Yes 2 ☐ No 5 Other (specify) sate has been signed by the page 2 should be detached 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. \$ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy certificate 1 ☐Yes 2 ☐ No 1 ☐ Yes 3 ☐ No director, 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: ≥ ER/Outpatient 3 □ DOA 2 **□** No 1 Tes 1 Inpatient Certification: To this funeral 28d. Describe how injury occurred 28a. Date of Injury (Month, Day, Year) 28b. Time of 27. Manner of Death 28c. Injury at Work? After 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 24 hours after death. 2 Accident filled in by the 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number City or Town, State) 3 Suicide 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical 29a. Certifier (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) completely and manner stated. within 2 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number

3altimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

State Registrar

HOSPITAL 32. Registra s Signature 31. Date filed (Month, Day, Year) MAR 2 2011

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

N. Merdono

MD

ROAD

HD DOO 60638

PRINCE

26/11

206

FREDERICK

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend Item# 7, per fh, g916, 6-28-11 sm State of Maryland Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month 2 Physician/ Year Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Washington Adventist Hospital Takoma Park Montgomery Social Security Number 8. Date of Birth (Month, Day, Year) **Funeral** Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign 1 M 2 XF Months Director MĎ 215-46-4541 ugust 13, 1944 Usual Residence of Decedent ortant: If item 27 is marked other than "natural", or items 23a or 28a-f show injury or other traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 No Calvert **Owings** 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? by Funeral 7244 Clyde Jones Road 20736 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian Armed Forces?
1 ☐ Yes 2 X No Black, White, etc. 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 K No Specify: If Yes, Give 3 Divorced 4 Divorced Completed Black 15. Decedent's Education cify only highest grade completed) Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry should be filed within 72 and Mental Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) unk Housewife Own Home Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 Catherine Stepney Paul Harris 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 sh Department of Health ar Important: If item 27 is any injury or other trau Glendora Chisley - daughter 7669 Rona Court Apt. I, Glen Burnie, MD 21061 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 🗷 Burial 2 🗆 Cremation 3 🗆 Removal from State **Holland Cemetery** March 29, 2011 4 Donation 5 Other (Specify) Huntingtown, MD 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Sewell Funeral Home, P.A. Blady 1451 Dares Beach Rd., Prince Frederick, MD 20678 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on sach line Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of) Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Month Pregnant at time of death 5 Other (specify) ed by the a detached t 9 Unknown 9 Unknown P.O. s been signed b Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Records, 1 🗌 Yes 2 ☐ No 3 ☐ Probably 4 🔼 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an page 2 autopsy 25. Was case referred to medical examiner? Division of Vital funeral director Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: မ 1 Yes 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA this 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred Natural 5 Pending work? 24 hours after death. Funeral Director: A 2 🗌 No Accident Investigation completed filled in by the 3 Suicide 4 Homicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier Ecrtifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 🗆 within 2 To the F only one) Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier of person who completed cause of death (Item 23a) (Type, Print) LRU arrol State MAR 28 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death FONTAINE Physician/ Month SUCBRANDSEN LIZABETH Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner SHOLERSVILLE QUEEN ANNES If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) 8. Date of Birth Social Security Numbe 6. Sex 7. Age (In yrs. last birthday) **Funeral** 1 □ M 2 💢 F (Month, Day, 050602 Director Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits be filed within 72 hours after death with the Maryland at Director "natural", or items 23a or 28a-f s edical Examiner must be notified KENT CHESTERTOWN 1 X Yes 2 No 10g. Citizen of What Country? STREET CROSS Funeral SOUTH 21620 4.5.4 Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces 1 Never Married 2 Married Completed by ☐ Yes 2 No Maryland 21215-0036 1 ☐ Yes 2 X No Specify. If Yes, Give Year or Dates Specify: LUHITE 3 Widowed 4 Divorced the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business Industry and Mental Hygiene. is marked other than Elementary/Seconday (0-12) College (1-4 or 5+) HOMEMAKER OMEMAKER event, Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည BARWICK SSEL permit. Page 1 and 2 should be Department of Health and Ment Important: If item 27 is marke any injury or other traumatic once. 19a. Informant's Name/Relationship (Type, Print) 21620 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) CHESTERTOWN HD GULBRANDSEN 307 OLD FAIRLES ROAD Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State cemetery, crematory or other place) 22/2011 HESAPE HESTEL 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licenses 22. Name and Address of Facility 207 6286.0 WILLIAMS, JE MALVIN RO 23a. Part 1/Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate shock, or heart failure. List only one cause on each line. Interval Between Immediate Cause (Final Onset and Death Physician/ TAILURE disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury Examiner Due to (or as a consequence oi): that the death certificate be executed burial-transi and that initiated events resulting in death) Last Due to (or as a consequence of): the attending physician thed for use as the buria Physician/Medical Records, P.O. Box 68760 IF FEMALE: 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ Live Birth 2 Fetal death in the past 12 months?
1 ☐ Yes 2 ☐ No Day Year Month Pregnant at time of death filled in by the funeral director, page 2 should be detached g 🗌 Unknown been signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 Hospital or Attending Physician: The law requires 1. 24 hours after death.

Funeral Director. After this certificate how home in 1 ☐ Yes 2 ■ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an performed? Yes 2 No 1 ☐ Yes 2 ☐ No Division of Vital 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital: Other: 2 🙋 No မ 1 Yes 1 Inpatient 2 I ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 🐼 Other (Specify) CAL House after death. Director: After this 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred 1 🗷 Natural 5 Pending 1 Yes 2 No Accident Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 29a. Certifier 🏿 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check within 2 To the F only one 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 0 2/1 23 6 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar

DHMH 17 Rev 7/2009

State

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VK.

31. Date filed (Month, Day, Year)

4,1).

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State
RegistraMEND#16perIME, 3/31/11; BMW, McCo Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** 5-450019 migrah 2011 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Sulver SDITIY 4114 Grand 3 337771 If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Sept. 9. 9. Bifthplace (State or Foreign Social Security Number 7. Age (In vrs. last birthday) 6 Sex **Funeral** Months Days Hours Min 157 M 2□ F Yrs. Sept. 64 Director 209-34-3275 Usual Residence of Decedent 10d. Inside City Limits 10b. County 10c. City. Town or Location show item 27 is marked other than "natural", or Items 23a or 28a-f show other traumatic event, the Modical Examination in Author to Indianal and Item (Indiana). 1 ☐ Yes 2 F No Director Poland Ohio Mahoning 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? USA Funeral 6394 Tara Drive 44514 Pages 1 and 2 should be filed within 72 hours after death vent of Health and Mental Hygiene. Int: If item 27 is marked other than "natural", or Items 23. 12. Was Decedent Ever in U.S. Armed Forces? 1 ™s 2 □ No If Yes, Give Year or Dates: Vietnam 14. Race - American Indian. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2√☐ No Specify.White Specify. Completed by 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Property/Project Manager Real Estate 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Cecelia Wojton Galka Joseph ဂ္ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 6394 Tara Drive, Poland, OH 44514 Linda D. Galka/Wife 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition Department of H Important: If ite any Injury or ot 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State March 201 30 Metropolitan Crematory 4 ☐ Donation 5 ☐ Other (Specify) Alexandria, VA 21. Signature of Funeral Service Licensee Francis Address of Facility Funeral Home Inc. 500 University Blvd. W., Silver Spring, MD 20901 23a. Part 1. Enter the disease, or complications that caused in death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** 2016 disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Ypy Tengi Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner with 24 hours after death. To certificate has been signed by the attending physician and to the Funeral Director. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of): P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy 5 Other (specify) ☐Yes 2 ☐ No 9 I Inknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 1 ☐Yes 2 No 1 ☐ Yes 2 ☐ No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home -5 Pe Hospital: 1⊠Yes 2□No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 27. Manner of Death 28d. Describe how injury occurred 5 Pending investigation 1 Natural 1 ☐Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Hospital 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a, Certifier Medical and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number MINIO DME 474 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

State Registr<u>ar</u> 31. Date filed (Month, Day, Year) NAR 3 1 2011

DHMH 17 Rev 1/2001

SI/UCI

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Joseph 30, 2011 12:45A M Wayne Gross, Sr. March /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death **Examiner** 8595 Neptune Lane Bel Alton Charles If Under 1 Year | If Under 24 Hrs. Hours | Min. 8. Date of Birth (Month, Day, Year)
July 30,1946 Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** 1 ★ M 2 □ F 169-38-5268 64 PÁ Director Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mertal Hyglene.
ant: If Item 27 is marked other than "natural", or Items 23a or 28a-f show uny or other traumatic event, I'm Merical Even ment and the natural any or other traumatic event, I'm Merical Even ment and the natural and any or other traumatic event, I'm Merical Even ment and the natural and any or other traumatic event, I'm Merical Even ment and any other traumatic event, I'm Merical Even ment and any other traumatic event, I'm Merical Even ment and any other traumatic event, I'm Merical Even ment and any other traumatic event, I'm Merical Even ment and any other traumatic event. 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County 1 ☐ Yes 2 X No Director MD Charles Bel Alton 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 8595 Neptune Lane 20611 USA Funeral 12. Was Decedent Ever in U.S. Acmed Forces? 1 ⊠Yes 2 □ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 □Yes 2X No Specify White δ Specify: 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) College (1-4or 5+) Elementary/Secondary (0-12) Chief Finacial Officer Accounting 18. Mother's Name (First, Middle, Malden Surname) 17. Father's Name (First, Middle, Last) Be Charles Gross Mary Seymore ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) permit. Pages 1 and 2 Department of Health Important: If Item 27 any injury or other tr once. Sharyn Gross/Wife 8595 Neptune Lane, Bel Alton, MD 20611 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ☐ Burial 2 🗡 Cremation 3 ☐ Removal from State Brinsfield-Echols Crem.4/2/2011 Charlotte Hall, MD 4 ☐ Donation 5 ☐ Other (Specify) M00945 21. Signature of Funeral Service Licenses 22 AREHART-ECHOLS FUNERAL HOME, P.A. au 211 St. Mary's Ave. La Plata,MD 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final CAYCER **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter thin enjoying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-trar Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy Month Day Year in the past 12 months? 4 Pregnant at time of death 5 ☐ Other (specify) 1 □Yes 2 □ No certificate has been signed by the rector, page 2 should be detached 9 D Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 3 Probably 4 Unknown 1 ☐ Yes 2 ☐ No Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No 24a, Was an autopsy performed? 1 ☐Yes 2 ☐No within 24 hours after death.

To the Funeral Director; After this certific completely filled in by the funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one, Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1☐ Yes 2년 No 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 ☐ Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Wedical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical and manner stated the 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year)

State

Registrar

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

201

32. Registrar's Signature

31. Date filed (Month, Day, Year)

APR 0

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death April 02Day Physician/ Gregory A Guzrrero 2011 07:48 A M Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Ballimore Maryland Modical (ente If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth **Funeral** 063-92-1481 1 **X** M 2 □ F Months Days Hours Min. 02/02/1986 25 bominican Republic Director Usual Residence of Decedent ral", or items 23a or 28a-f shov Examiner must be notified at 10d. Inside City Limits 10c. City, Town or Location permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho any injury or other traumatic event, the Medical Examiner must be notified at 10b. County 10a. State Director NY Bronx Bronx Yes 2 No 10g. Citizen of What Country? 10e. Street and Numbe 10f. Zip Code 10457 Funeral Weeks Avenue Apt#3 1801 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces 1 Yes 2 XNo Black, White, etc. 1 Never Married 2 Married Completed by 1 XYes 2 □ No Specify Dominican Baltimore, Maryland 21215-0036 Specify.Hispanic 3 🗌 Widowed 4 🗌 Divorced Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Maintenance Commercial Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Dante Guerrero Mayra Videl Mejia 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Carina Guerrero, Wife 1801 Weeks Ave. Bronx, NY 10457 20b. Place of Disposition (Name of Marphite), cerowe oparities. 20c. Location - City or Town, State Hackensack, NJ 20a. Method of Disposition 04/08/2011 1 Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Cemetery Name and Address of Facility R.G. Ortiz Funeral Home . Signature of Funeral Service Licenses 2580 Grand Concourse; Bronx, NY 10458 Beach Cato M01613 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final Cerebial 主dema Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of):
Fulminant H 2Patic Examiner Fulminant Sequentially list conditions, if any, reading to in mediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Examine Juni to for an a consecuence offi Hapatiti 8 Autoimmune Hospital or Attending Physician: The law requires that the death certificate be executed resulting in death) Last the burial attending physician Physician/Medical Division of Vital Records, P.O. Box 68760 for use as IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months?

1 Yes 2 No
9 Unknown Month Day Year Pregnant at time of death 24 hours after death.

Funeral Director: After this certificate has been signed by the seted filled in by the funeral director, page 2 should be detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 🗌 Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Hospital: 2 No 1 Tes 1 🗹 Inpatient 2 🗆 ER/Outpatient 3 DOA ၉ 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: work? 1 ☐ Yes 2 ☐ No 1 Matural 5 Pending Accident Investigation 6 Could not be 3 ☐ Suicide 4 ☐ Homicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier 1 🗹 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. completed 3 🖂 within 2 only one) 29b. Signature and title of certifier 2011 address of person who completed cause of death (Item 23a) (Type, Print) +2 Greene St. Ballimore, MD

Registrar DHMH 17 Rev 7/2009

State

31. Date filed (Month, Day, Year)

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22

egistrar's Signature

32

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Amend Item 25 State of Maryland / Penartment of Health and Mental Hygiene Certificate of Death Registrar 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Day P^{M} 2011 1:55 Sidney Greenfield Medical March 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death <u>Montgomery</u> Casey House ${ t Rockville}$ Birthplace (State or Foreign Country)
 New York **Funeral** 7. Age (In vrs. last birthday) If Unde If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 03/30/1914 1 X M 2 □ F Months Hours Min. **Director** Yrs 059-10-7746 96 Usual Residence of Decedent 10a. State 10b, County items 23a or 28a-f sho ner must be notified at 10c. City, Town or Location 10d. Inside City Limits Page 1 and 2 should be filed within 72 hours after death with the Maryland Director 1X Yes 2 □ No Rockville MD Montgomery 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 14431 Traville Garden Circle 20850 12. Was Decedent Ever in U.S. Armed Forces?

1

X Yes 2 □ No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Examiner Black, White, etc ö 1 Never Married 2 X Married þ Maryland 21215-0036 1 Yes 2 X No Specify: "natural", Specify. Completed 3 Widowed 4 Divorced Year or Dates WW - T T White the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) al Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) Store Owner Jewelry Department of Health and Mental Hygi Important: If item 27 is marked othe any injury or other traumatic event, i Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ <u>Emanuel Greenfield</u> <u>Regina Lebovitz</u> 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <u> Howard Greenfield / Son</u> Flowerfield Way Potomac MD20852 Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place)
Judean
Memorial Gardens 20a. Method of Disposition 20c. Location - City or Town, State 1 X Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 03/27/2011 Olney, Maryland 22. Name and Address of Facility
Edward Sagel Funeral Direction Inc. Signature of Funeral Service Licenses **Blake** 1091 Rockville Pike Rockville. 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition GI Bleed Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease of injury that initiated events Examine Due to (or as a consequence of): burial-transit CERTIFICATION APPROVED BY MEDICA Due to (or as a consequence of): resulting in death) Last attending physiclan for use as the burial Physician/Medical Hospital or Attending Physician: The law requires that the death certificate be Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months?

1 Yes 2 No Day Pregnant at time of death signed by the a d be detached t 9 Unknown g Unknown P.O. | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Division of Vital Records, 1 ☐ Yes 2 X No 3 ☐ Probably 4 ☐ Unknown Completed page 2 should peen 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an has autopsy performed? Yes 2 X No certificate filled in by the funeral director, Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 4 \square Nursing Home 5 \square Residence 6X Other (Specify) Hospice မ 1 Inpatient 2 I ER/Outpatient 3 I DOA 24 hours after death. Funeral Director: After this 28a. Date of injury (Month, Day, Year) Certificate: 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 🕅 Natural work? 1 Yes 2 No 5 Pending injury Accident Investigation Suicide 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. completed Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check within 2 only one 29b. Signature and title 29c. License number 29d. Date signed (Month, Day, Year) R143201 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Debrah Miller, CRNP

State Registrar

DHMH 17 Rev 7/2009

31. Date filed (Month, Day, Year)

MAR

29 2011

82. Registrar's Signature

6001 Muncaster Mill Rd. Rockville, MD 20855

11-02700 William Phillip Grubb Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible
State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

	Re	gistrar			Sertificate	oi Deaiii				Reg. No.		
Physician Medical Examine	1.	Decedent's Name (First, Midd William Phill					2. Date of Death Month Day April 8, 2011					3. Time of Death 1635 hrs
	4a	4a. Facility Name (if not institution, give street and number) 413 Underwood Circle 4b. City, Town, or Location of Bel Air								4c. County Harford	of Death	
Funeral Director	5.	Social Security Number	6. Sex		yrs. last birthday)		Year If Und			hirth (MM/DD/YYY)	Foreign	
	_	213-84-8464 sual Residence of Decedent	1 M 2 F			Yrs.			02/0	06/1962		try)Maryland
id how any		10a. State 10b. County 10c. City, Town or Location										0d. Inside City Limits 1 Yes 2 No
Baltimore, MD 21215-0036 Permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiere. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show injury or other traumatic event, the Medical Examiner must be notified at once. To Re Commissed by Elizarial Director	10	10e. Street and Number 10f. Zip Code								10g. Citizen of W	hat Countr	y?
th the notified notified		413 Underwood				210				U.S.A		
leath w		. Marital Status X Never Married 2 M	arried 12. Was Dec			Nas Decedent of Yes, specify Cu					e, etc.	n Indian, Black,
s after of	حٰاۃ		orced If Yes, Give Yes	ar	1[Yes 2X					Whit	
5-0036 ed within 72 hour lygiene. other than "natur the Medical Exam	ם מופר	 Decedent's Education (Spe Elementary/Secondary (0-12) 				ent's Usual Occ most of working				16b. Kind of Bu	usiness/Ind	lustry
MD 21215-0036 d 2 should be filed within 7 d 2 should be filed within 7 in an an arked other than numatic event, the Medica TO Re Connote	<u>.</u> 5	10 Father's Name (First, Middle,	Lock		Mar	nager	140.14-11-	J. M /F		Gas St		n
215- be filed mtal Hyg rked off		William C. Gr						rence		_	*)	
D 21, hould the mark is mark	19	a. Informant's Name/Relations			19b. Mai	ing Address (S	treet and Nur	mber or Rura	al Route Nu	mber, City or Tow	n, State, Z	ip Code)
and 2 sleath ar	20	William C. Gr	rubb (fa	ther)	4312 Ob. Place of Disp				Road Date	- Perry		
ages 1 ant of H	1	X Burial 2 Cremation		om State	crematory or	other place)					•	
Baltimore, permit. Pages 1 an Department of Hea Important: Wite Injury or other tr	21	Donation 5 Other Sp Signature of Funeral Service	pecify: Licensee		ake-Vie	W Mem. I Name and Add	ress of Facilit	104/14	. Lass	ahn Fun	eral	Maryland Home, P.A.
	22	a. Part I. Enter the disease, or	sadns	augad tha d								
Physician /Medical		failure. List only one cause	on each line.		of Liv		ing, such as t	Saldiac of Te	sspiratory ai	rest, shock, of fie	ait	Between Onset and Death
£xaminer		mediate Cause (Final disease condition resulting in death)	Due to (or as a			CI						
100	Se if a	equentially list conditions, any, leading to immediate	b. Due to (or as a	consequen	ce of):					•		 -
ted	cause. Enter Underlying Cause (Oisease or injury that initiated events resulting in death) Last Due to (or as a consequence of):										<u> </u>	
18760, Tificate be executed ing physician and as the burial - transit as the burial - transit and Medical Ex	<u> </u>	X UNPENDED	dAMENDED	232	27 per m	o c01/	4_22_1	1 wt				
8760, tificate be execu ng physician and as the burial - tra	IF	FEMALE:	23c. If yes,			6 6714	4 22 1	1 46		23d. Date of	delivery	
6876 certificate nding phy se as the	23b	. Was decedent pregnant in the past 12 months?	e 1 Live b		2 🗌	Fetal death	3 Ectopi	c pregnancy	/	Month	Day	/ Year
5. Box 6 true death cer by the attendiached for use.	1[Yes 2 No 9 Unk	unown 9 Unkno	own	3 🗀	Other (Specify)						
P.O. Box 68 es that the death cert igned by the attendir se detached for use a lby Physicia	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contributing to death but not resulting in the underlying cause given in Part I. 1 Yes 2 No. 3											
Records, P.C. The law requires that ficate has been signed page 2 should be dear Completed by								_	24a. Was	an 24b. V	Vere autor	osy findings available
Reco The law cate has									perfe	ormed?	leath?	2 No
tal Rection: The certificate rector, page		. Was case referred to medical examiner?	Hospital:				Other	<u> </u>		1		
of Vision Physical Ph	27	1 ✓ Yes 2 No Manner of Death	28a. Date (Month	of Injury	ER/Outpatie		Injury at Work			Residence 6 how injury occurr		cene
ion of trending Pt leath. tor: After the funeral	1 2	Natural 5 Pend Accident Inves		, Day,Year)		1[Yes 2	No No				
Division of Vital Records, oppital or Attending Physician: The law requirments after death. Internal Director: After this certificate has been siy filled in by the funeral director, page 2 should to Certification: To Be Completed Certification: To Be Completed	3	Suicide 6 Could		e of Injury - A	At home, farm, st	reet, factory, offi	ce building, et	tc. 28	f. Location or Town,		er or Rural	Route Number, City
8 4 8 5	1 292	a. Certifier 1 Certifying Ph	nysician: To the bes									ause(s)
To the Ho within 24 To the Free completed	29t	Signature and title of certifie	and manner s				ense number			29d. Date sign		` '
$-(\zeta)$		Mayerie)	me Usu	ll		0.	C.M.E.			April 9, 201	11	
	30.	Name and address of person Margarita Korell MD.	who completed caus Assistant Med			Penn Street	Baltimore	e, MD 212	201			
State	31.	Date filed (Month, Day Year)		edstrar's Sig	nature A	parker						
Registra	Life .	ALU 4	LVIII /	- W -								

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death March 28,2011 Physician/ Hatmaker 9:38 A.M Mitchell Dean Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** North Beach Calvert 3838 0ak Street If Under 1 Year | If Under 24 Hrs. g. Birthplace (State or Foreign Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth **Funeral** 1 🕅 M 2 🗆 F Days Min. 0671071959 Maryland 51 217-76-5277 Director Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at one. 10b. County 10a. State 10c. City, Town or Location 10d. Inside City Limits Director 1 ☐ Yes 2 X No MD Calvert North Beach 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral U.S.A. 3838 0ak Street 20714 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces ò 1 X Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 XNo Specify: If Yes, Give 3 Divorced 4 Divorced white Completed Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) construction sheet metal worker Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) ဂ္ Sinks Frances Eugene Hatmaker Alma Richard 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2441 Plum Point Rd., Huntingtown, MD Rose Cranford, sister 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Metropolitan Crematorÿ04/01/2011 Alexandria, VA Oignature of Funeral Service Licensee 22. Name and Address of Facility Rausch Funeral Home, P.A. 8325 Mt. Harmony Lane, Owings, MD se, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, List only one cause on each line. 23a. Part 1. Enter the disea shock, or heart failure Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ CO DOPR disease or condition Medical resulting in death) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Examine Due to (or as a consequence of) attending physician and for use as the burial-transit faw requires that the death certificate be executed that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months? Month Year Day Pregnant at time of death Yes 2 No s been signed by the should be detached 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Records, 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy performed death? 1 Yes 2 No Yes 25. Was case referred to medical examiner? Hospital or Attending Physician: Be **Division of Vital** funeral director, 26. Place of Death (Check only one) 1 Yes 2 No 2 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: work? 1 Natural 5 Pending iniury 24 hours after death. Funeral Director: A 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, completed filled in by determined City or Town, State) Medical Certifying Physician: To the best of myknowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifie (Check Medical Examiner: On the basis of exam nation and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practioner: To the best f my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated To the I within 2 To the I Signature 29d. Date signed (Month, Day, Year) of person who completed cause of death (Item 23a) (Type, Print) and address drw Prince Fred Merrinac C Koymon A 1 31. Date filed (Month, Day, Year) 238 State

DHMH 17 Rev 7/2009

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygienery State
Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day 2011 Physician/ Month P^{M} 18 William | March :35 Charles Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 2515 Solomons Island Road North Calvert <u>Huntingtown</u> Social Security Number Year If Under 24 Hrs. 8. Date of Birth If Under 1 9. Birthplace (State or Foreign **Funeral** Age (In yrs. last birthday) 1 🕅 M 2 🗆 F Months Days Hours Min. Director Maryland 213-38-3460 Usual Residence of Decedent or 28a-f show 10a. State 10b. County Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits Director 1 ☐ Yes 2 🔀 No Calvert Huntingtown 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral items 23a 20639 2515 Solomons Island Road, North USA permit, Page 1 and 2 should be filed within 72 hours after death 1 Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items any injury or other traumatic event, the Medical Examiner mu 12. Was Decedent Ever in U.S. Armed Forces?
1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. þ 1 X Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify: Completed 3 Divorced White 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life, DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) 12 painter house painting 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Hooper Audrey May 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Debbie K. Whelan, cousin 3375 Bayside Road, Huntingtown, MD 20639 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 N Burial 2 Cremation 3 Removal from State 4 Donation 5 DOther (Specify) 03-25-2011 Miranda Cemetery Huntingtown, MD 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Rausch Funeral Home, P.A. Willow 8325 Mt. Harmony Lane, Owings, MD 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Onset and Death Physician/ Metastal disease or condition resulting in death) Medical Due to (or as a consequence of) 4 well Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of): Exami The law requires that the death certificate be executed the burial-transit Cause (Disease or linjury that initiated events resulting in death) Last Due to (or as a consequence of): signed by the attending physician at be detached for use as the burial. Physician/Medical 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day Year Pregnant at time of death 1 ☐ Yes 2 ☐ Unknown Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ Completed 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of 24a. Was an has autopsy perform death? certificate 1 Yes Yes I or Attending Physician: after death.
Director: After this certifica 25. Was case referred to medical completed filled in by the funeral director, Be 26. Place of Death (Check only one) examiner? 2 No 1 Tyes Other: ၉ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? Certificate: 28d. Describe how injury occurred 1 Natural 2 Accident 3 Suicide 5 Pending injury 1 Yes 2 No Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Medical 29a. Certifier Sertifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 1 Sertifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 1)0027189 2011 onsei who completed cause of death (Item 23a) (Type, Print) 30. Name and address of person Island Rd., Huntingtown 2417 Solomon's Yousat, M.D. 31. Date filed (Month, Day 32. Registra Registrar

Box 68760

Division of Vital Records,

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State
Registra PMEND#24a/b+25perMD, 4/11/11; BWW, Moo Certificate of Death Reg. No. I. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 03/28/2011 CLARENCE EARL HARDY, JR. 0147 М Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Montgomery Shady Grove Adventist Hospital Rockville 10 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 □**X**M 2 □ F Months Days Hours Min. 3 07/02/1944 **Director** 66 241-68-1464 Usual Residence of Decedent 1104/85/2 show 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits with the Maryland notified at Director 28a-f North Potomac 1 X Yes 2 No MD Montgomery 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ritems 23a or ner must be n Funeral USA 20878 12001 Golden Twig Court death 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14. Race - American Indian. "natural", or iter edical Examiner Armed Forces?

1 Yes 2 No If Yes, specify Cuban, Mexican, Puerto Rican, etc. þ 1 Never Married 2 Married Maryland 21215-0036 1 Yes 2 XNo Specify: If Yes, Give Completed 3 Widowed 4 Divorced Black Year or Dates the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working 16b. Kind of Business Industry (Specify only highest grade completed) 2 should be filed within 72 h and Mental Hygiene. 7 is marked other than "r. life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Federal Government EPA Executive Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ဂ္ Maude Important: If item 27 is marke any injury or other traumatic once. Clarence E. Hardy, Sr. Page 1 and 2 should ment of Health and Mr 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 12001 Golden Twig Court, North Potomac, MD 20878 Mae A. Hardy/wife Baltimore, 20a. Method of Disposition ce of Disposition (Name of etery, crematory or other place) Date 20c. Location - City or Town, State ☐ Burial 2 Cremation 3 ☐ Removal from 4 Donation 5 Other (Specify) Abodent Cremation Svc 04/01/11 Hanover, MD 22. Name and Address of Facility Snowden Funeral Home 21. Signatury of Funeral Servic Licer 246 N. Washington St, Rockville, MD 20850 23a. Part 1. Enter the disease, or co shock, or heart failure. List onl cations that caused the dea Do not enter the mode of dying, such as cardiac or respiratory arrest, se, or cor Interval Between Onset and Death Immediate Cause (Final Physician/ Myoca disease or condition / Medical resulting in death) Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate Examiner Due to (or as a consequence of) 6 cause. Enter Underlying or Attending Physician: The law requires that the death certificate be executed Cause (Disease or iinjury that initiated events resulting in death) Last Due to (or as a consequence of) the burialattending physician Physician/Medical Division of Vital Records, P.O. Box 68760 use as IE FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Month Year Day Pregnant at time of death 5 Other (specify) signed by the at be detached for signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Completed page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performed? Yes 2 No certificate 1 ☐ Yes 🗶 No director, 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner' Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 **X** No 1 🗌 Yes မှ 1 ☐ Inpatient 2 X ER/Outpatient 3 ☐ DOA this funeral 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? Certificate: 28d. Describe how injury occurred Natural Natural 5 \square Pending injury 1 Yes 2 No Investigation Accident filled in by the within 24 hours after deatl

To the Funeral Director;
completed filled in by the 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined To the Hospital Medical 29a. Certifier 🗷 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 3 🗆 only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month. Day, Year) 10 March 28, 2011 mo D00064068 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Medical Cor Dr Rockville, MD 20850 Ami Kalaria MD 9901 31. Date filed (Month, Day, Year) Registrar's Sign: MAR 3 1 2011 State Registrar

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene, for State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) March 25, Day 2011 Year Physician/ 10:37 A M Cheryl Ann Harrod Medical 4c. County of Death 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner Prince George's Cheverly Prince George's Hospital Center Birthplace (State or Foreign Country)
 DC 8. Date of Birth Jan. 10, 1953 If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) 5. Social Security Number 6. Sex **Funeral** 1 □ M 2 🕱 F Months Days Hours Min. DC Director 212-64-4540 58 Usual Residence of Decedent 10d. Inside City Limits 28a-f shov 10c. City, Town or Location 10a. State 10h County ed other than "natural", or items 23a or 28a-f sho event, the Medical Examiner must be notified at Director 1 X Yes 2 No Glenarden Maryland Prince George's 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number Funeral United States 20706 3200 Reed Street Apt. # 2112 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Race - American Indian 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Black, White, etc. 1 ☐ Yes 2 ☒No If Yes, Give δ 1 Never Married 2 Married Specify: African Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: 3 X Widowed 4 Divorced Completed American Year or Dates 16b. Kind of Business Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Private Nursing Assistant 12th Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) should be filed h and Mental H 7 is marked ot မ Ruth Mary Bright Roger Richardson Sr. other traumatic 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Glenarden, Md. 20706 3200 Reed Street Apt. # 2112 Page 1 and 2 sl ment of Health a Joyce A. Harrison - Sister 20c. Location - City or Town, State 20b. Place of Disposition (Name of 20a. Method of Disposition permit, Page 1 a Department of H Important: If ite any injury or ot cemetery crematory or other place) Maryland Veterans 1 🖾 Burial 2 🗆 Cremation 3 🗆 Removal from State Cheltenham, Maryland 4 ☐ Donation 5 ☐ Other (Specify) Cemetery 22. Name and Address of Facility Stewart Funeral Home, Signature of Funeral Service Licensee swair 4001 Benning Road NE Washington, DC 23a. P. rt 1 Inter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, show, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final 266212 Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of): cordiamy a satting Examiner Ischemic Sequentially list conditions, Due to (or as a consequence of): Examine Irsyl physician and s the burial-transit Cause (Disease or linjury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical that the death certificate be 68760 use as attending plant in for use as IF FEMALE: yes, outcome of pregnancy
Live Birth 2 Fetal death 3 Ectopic pregnancy 23d. Date of delivery 23b. Was decedent pregnant Box (in the past 12 months?
1 Yes 2 No Month Year Day Pregnant at time of death 5 Other (specify) 9 Unknown P.O. 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ the Hospital or Attending Physician: The law requires thin 24 hours after death.

the Funeral Director: After this certificate has been sign 1 ☐ Yes 2 🕅 No 3 ☐ Probably 4 ☐ Unknown Division of Vital Records, Completed After this certificate has been si funeral director, page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 No 1 Yes 2 No 26. Place of Death (Check only one) 25. Was case referred to medical Be examiner? Other: 2 🔀 No 1 Nanpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) မ 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at Medical Certificate: 27. Manner of Death 28d. Describe how injury occurred work?
1 Yes 2 No 1 ANatural 5 Pending 2 Accident
3 Suicide Investigation 6 Could not be the 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) completed filled in by determined 1 🖔 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. within 2 29d. Date signed (Month, Day, Year) muxemie modella, mo 18992000 3/25 12011 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) My Kemil Abdella, mis 3001 Hospital Drive Cheverly, Md. 20785 31. Date filed (Month, Day, Year) APR 0 1 2011 32. Registraris Signature State

DHMH 17 Rev 7/2009

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Year Physician/ Hill 1144 James Donald Medical 4a. Facility Name (if not institution, give street and number, 4b. City, Town, or Location of Death 4c. County of Death . Examiner KegioNAL SALISBUTU HIOVALOO TENINSULA If Under 1 Year If Under 24 Hrs. g. Birthplace (State or Foreign Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth Funeral 1 🗓 M 2 🗆 F Days Jan. 9, 1936 Months Hours Min. 220-32-0923 75 Maryland Yrs **Director** Usual Residence of Decedent items 23a or 28a-f shov 10a. State 10b. County event, the Medical Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits Director MDDorchester Cambridge 1 X Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 1604 Race Street 21613 USA 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11 Marital Status 14. Race - American Indian Armed Forces?
1 ☐ Yes 2 🔼 No Black, White, etc. ō þ 1 Never Married 2 Married Maryland 21215-0036 white If Yes, Give Year or Dates 1 ☐ Yes 2 K No Specify: "natural", 3 Widowed 4 Divorced Completed 15 Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) should be filed within 72 I h and Mental Hygiene. **7 is marked other than "r** Elementary/Seconday (0-12) College (1-4 or 5+) truck driver freight transport Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည John Willie Hill Mildred Cannon 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 sh Department of Health ar Important; If item 27 is any injury or other trau wife Margaret A. Hill 1604 Race St., Cambridge, MD 21613 Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Date 1 🖾 Burial 2 🗆 Cremation 3 🗆 Removal from State Spedden Seward Cem. 3/31/11 Cambridge, MD 4 Donation 5 Other (Specify) 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Thomas Funeral Home P.A. 700 Locust St., Cambridge, MD 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Betweer shock, or heart failure. List only one cause on each line Immediate Cause (Final Onset and Death Physician Multipl disease or condition resulting in death) 48hows Medical Due to (or as a consequence of): Examiner Sequentially list conditions Examine cause. Enter Underlying Cause (Disease or iinjury Due to lor as a consequence of To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the hurial-transit that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day Year 5 Other (specify) Pregnant at time of death g 🗌 Unknown g 🗌 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy Yes 2 N 1 ☐ Yes 2 🕅 No 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 10 1 MInpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at work? 1 ☐ Yes 2 ☑ No Certificate: 28d. Describe how injury occurred 5 Pending injury 1 Natural MVC 2330 Investigation 6 Could not be 3125/11 2 Accident 3 Suicide 4 Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Road KT343 Cantroge Porchs by Court y Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Cod Bata signed (Month Per (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated only one 29b. Signature and 29c. License number 29d. Date signed (Month, Day, Year) H50497 3 29 11 DWF

Registrar

State

100 E Carroll

Registrár's Signa

Salishy

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

D.O. OMF

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death March 24, 2011 Physician/ 23:42 M. Hill Ruth Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 2211C If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign Age (In yrs. last bir **Funeral** Months Days 1 🗆 M 2 🔼 F Hours o#\###1929 Maryland 81 **Director** 218-20-8004 Usual Residence of Decedent show or 28a-f shov notified at 10d. Inside City Limits 10a. State 10b. County 10c. City. Town or Location 72 hours after death with the Maryland Director 1 Yes 2 X No Salisbury Maryland Wicomico 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Numbe 9 and Mental Hygiene. I is marked other than "natural", or items 23a or raumatic event, the Medical Examiner must be I Funeral USA 21804 6117 Florence St. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. 11. Marital Status Armed Force Black. White, etc 2 X No þ 1 Never Married 2 Married Yes Maryland 21215-0036 1 Yes 2 No Specify: If Yes. Give Specify: White 3 X Widowed 4 Divorced Completed Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15 Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Domestic Homemaker Be should be filed 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) ဂ Helen Travers John Adams 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) permit. Page 1 and 2 sh Department of Health al Important: If item 27 is 31221 Mt. Hermon Rd., Salisbury, Maryland 21804 <u>Debbie Dize|daughter</u> or other Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place)
Salisbury Crematory 20c. Location - City or Town, State 20a. Method of Disposition 1 🗌 Burial 2 🕱 Cremation 3 🗌 Removal from State Salisbury, Maryland 03 | 25 | 2011 injury 4 Donation 5 Other (Specify) 21. Signature of Fulheral Service Licens 22. Name and Address of Facility Holloway Funeral Home P.A. 501 Snow Hill Rd., Salisbu any Maryland 21804 Salisbury, 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line. Immediate Cause (Final Physician/ Schemic he inormay 12 disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Meron Sequentially list conditions Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of hiratron the Hospital or Attending Physician: The law requires that the death certificate be executed sician and burial-trans that initiated events resulting in death) Last Due to (or as a consequence of attending physician for use as the burial where - Systolie Bystunger Physician/Medical P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregna 5 Other (specify) Ectopic pregnancy in the past 12 months? Month Year Day Pregnant at time of death 2 No signed by the a ld be detached f 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown Division of Vital Records, Completed is certificate has been si director, page 2 should I 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 1 ☐ Yes 2 ☐ No 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 🖸 No ဂ္ 1 🗹 Inpatient 2 🗆 ER/Outpatient 3 🗀 DOA within 24 hours after death.

To the Funeral Director: After this completed filled in by the funeral dir 28a. Date of injury (Month, Day, Year) 28b. Time of 27. Manner of Death 28c. Injury at 28d. Describe how injury occurred Certificate: 5 Pending ✓ Natural 1 ☐ Yes 2 ☐ No ☐ Accident ☐ Suicide Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 🗆 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month. Day, Year) D0067752 11 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 100 Canol saberi 31. Date filed (Month, Day, Year) 32. R gistrar's Signature State MAR 29 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day 22 Month Physician/ 2011 MAKCH 246 Lisa Gail Harris Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (if not institution, give street and number) Examiner alistur Peninsula Regional medical Center dicomic If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 8. Date of Birth **Funeral** (Month, Day, Year) -20-1967 Months 1 □ M 2 🗓 F Hours MD **Director** 213-90-5765 Usual Residence of Decedent 28a-f shov permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location Director 1 Yes 2X No Seaford DE Sussex 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number Funeral USA 19973 11054 Church Road Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. 11. Marital Status Armed Forces?
1 ☐ Yes 2X No Black, White, etc. ò 1 Never Married 2 X Married SpecifiBlack Baltimore, Maryland 21215-0036 1 ☐ Yes 2 XNo Specify: If Yes, Give 3 Widowed 4 Divorced Completed Year or Dates 15 Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Mid-Atlantic 12 Truck Driver Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) ည Ruth Ann Revelle Ukn 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Church Road, Seaford, DE 19973 <u>Richard Harris/Husband</u> 11054 20b. Place of Disposition (Name of cemetery, crematory or other place). 20c. Location - City or Town, State 1 ☐ Burial 2X Cremation 3 ☐ Removal from State 4 Donation 5 Other (Specify) 3-29-2011 Dover, DE Direct Cremation, Ignature of Funeral Service Licensee 22. Name and Address of Facility 17 W. Isabella St. MD 21801 Salisbury, Home Funeral 23a. Part.1 Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate shock, or heart failure. List only one cause on each line Interval Between Onset and Death Immediate Cause (Final a Severe Respiratory Acidosis Ph. sician/ disease or condition Medical resulting in death) Due to (or as a consequence Examiner Amyotrophic lateral sclerasis Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Physician/Medical Examiner Due to (or as a consequence of the attending physician and the for use as the burial-transit Cause (Disease or linjury that initiated events resulting in death) Last To the Hospital or Attending Physician; The law requires that the death certificate be executed Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death
4 Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No Month Day Year 5 Other (specify) 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performe 1 ☐ Yes 2 ☐ No after death.

Director: After this certificate Yes funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? 1 Tes 2 🕨 No Certificate: To 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 28b. Time of 27. Manner of Death 28c. Injury at 28d. Describe how injury occurred 1 Natural injury work?
1 Yes 2 No 5 \square Pending Investigation Accident filled in by the 3 ☐ Suicide 4 ☐ Homicide Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State within 24 hours a To the Funeral C Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifie 03 23 12011 D0070961 mosha Peters-Harris, MD leted cause of death (Item 23a) (Type, Print) SALISBUM MO 100 E. Date filed (Month, Day, Year) State MAR 30 Registrar

11-02441 Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. # 8State of Maryland / Department of Health and Mental Hygiene Willie W. Jones Amend#19aperfuneralhome 4944 figate of Death Reg. No. Registrar 1. Decedent's Name (First, Middle,Last) 2 Date of Death Time of Death Physician/ 0138 hrs March 30, 2011 **Medical Examiner** Willie Willard Jones 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Montgomery Takoma Park Washington Adventist Hospital 9. Birthplace (State or 7. Age (In yrs. last birthday) If Under 1 Year If Under 24Hrs. 8. Date of Birth(MM/DID/XXXXX) 5. Social Security Number **Funeral** Foreign Country) VA Months Days Director 79 Aug. 31, 1931 578 40 6940 1 M 2 F Yrs Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County 1 Yes 2 No s 23a or 28a-f show e optified at ooce. MD Charles Waldorf 28a-f show hours after death with the Maryland 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 5122 Alfred Drive 20601 USA 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No 14. Race - American Indian, Black, 11 Marital Status "natural", or items If Yes, specify Cuban, Mexican, Puerto Rican, etc.) White, etc. Armed Forces 1 Never Married 2 Married 1X Yes 2 Specify: Black If Yes, Give Year 1952-53 1 Yes 2 X No specify: 3 Widowed 4 Divorced Š 16a. Decedent's Usual Occupation (Give kind of work done 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Completed during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) should be filed within 72 l permit. Pages 1 and 2 should be filed within 72 Department of Health and Mental Hygiene. Important: If item 27 is marked other than injury or other traumatic event, the Medical Baltimore, MD 21215-0036 10th Private 18.Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Kate Williams Robert Jones, Sr. 19a. Informant's Name/Relationship (Type, Print)
Robbin
Robin
Robin 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) မှ Waldorf,MD 20601 5122 Alfred Dr. 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, Date 20a. Method of Disposition crematory or other place) 1 XBurial 2 Cremation 3 Removal from State Veteran Cemeter 14/12/2011 Cheltenham, MD Donation 5 Other Specify: 22. Name and Address of Facility 3riscoe-Tonic Funeral Home 21. Signature of Funeral Service Licen 2294 Old Washington Rd. Waldorf, MD 20601 23a. Parf. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart **Physician** Between Onset and failure. List only one cause on each line. /Medical Death a. Exsanguination Immediate Cause (Final disease xaminer Due to (or as a consequence of) or condition resulting in death) b. Erosion of Dialysis Shunt Sequentially list conditions, Due to (or as a consequence of): if any, leading to immediate Examine cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): the attending physician and ed for use as the burial - transi Hospital or Atteoding Physician: The law requires that the death certificate be executed Physician/Medical UNPENDED AMENDED Division of Vital Records, P.O. Box 68760, IF FEMALE 23c. If yes, outcome of pregnancy 23d. Date of delivery 3b. Was decedent pregnant in the Year 1 Live birth 3 Ectopic pregnancy Month Day 2 Fetal death past 12 months? Pregnant at time of death 5 Other (Specify) Yes 2 No 9 Unknown detached 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. seen signed by 2 1 Yes 2 No 3 Probably 4 V Unknown End stage renal disease Completed 24a Was an 24b Were autopsy findings available prior to completion of cause of autopsy certificate has l page 2 s performed death? ✓ Yes 2 No 1 Yes 2 No 26. Place of Death (Check only one) 25. Was case referred to medical Be examiner? Other Nursing Home 5 Residence 6 Other this ۵ 1 V Yes 2 No 28a. Date of Injury (Month, Day, Year) Mar 30, 2011 28d. Describe how injury occurred After 27. Manner of Death 28b. Time of Injury 28c. Injury at Work? Subject bled from dialysis shunt 1 Natural 0100 hrs Pending 1 Yes 2 V No J Director: ed in by the f within 24 hours after death.

To the Funeral Director: 2 🗸 Accident Investigation 28e. Place of Injury - At home, farm, street, factory, office building, etc 28f. Location (Street and Number or Rural Route Number, City Suicide 6 Could not be or Town, State) 4922 La Salle Road, Hyattsville, MD filled determined (Specify) Nursing Home Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Ga 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

31. Date filed (Month, Day, Year) 32 Registrar's Signature

round 30. Name and address of person who completed cause of death (Item 23a)

Assistant Medical Examiner

29b. Signature and title of certifier

Melissa Brassell, MD

29c. License number

O.C.M.E.

111 Penn Street, Baltimore, MD 21201

29d. Date signed (Month, Day, Year)

March 31, 2011

State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2 Date of Death 3. Time of Death Physician/ March 31,2011 6:30 A M James Ronald Johnson Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death 1382 Marshall St. Hagerstown Washington Social Security Number If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) 8. Date of Birth Funeral 1 **x** M 2 □ F Months Days 7.1936 Country Maryland 220-70-0963 **Director** November Usual Residence of Decedent 28a-f show 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits notified at Director ty☐ Yes 2 ☐ No Hagerstown Washington 10e. Street and Number 10f. Zip Code 6 10g. Citizen of What Country? the Medical Examiner must be Funeral items 23a 21740 1382 Marshall Street USA 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian Was Decedent Ever Armed Forces?

1 Yes 2 No If Yes, Give Year or Dates. Black. White, etc. ρ 1 😾 Never Married 2 🗌 Married Baltimore, Maryland 21215-0036 Specify: Black 1 ☐ Yes 2 ▼ No Specify: 'natural", Completed 3 Divorced 4 Divorced 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) none none Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) should be filed and Mental H is marked of 2 Georgette Elizabeth Unknown Andrew Reid Johnson permit. Page 1 and 2 should be Department of Health and Men Important: If item 27 is marke any injury or other traumatic 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Carol Sucker/Social Worker 1380 Marshall St., Hagerstown, MD 21740 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Cremation 3 Removal from State 5 Other (Specify) 1 X Burial 04/04/2011 4 Donation Rose Hill Cemetery Hagerstown, Maryland Signature of 22. Name and Address of Facility Gerald N. Minnich Funeral Home 305 N. Potomac St., Hagerstown, MD 21740 of the disease, or complications hat caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, leart failure. List only one cause (in each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ dementia disease or condition le ars Medical resulting in death) Due to (or as a consequence of): Examiner buns Syndrome Sequentially list conditions, Due to (or as a consequence of) if any, leading to immediate Exami attending physician and for use as the burial-transit Cause (Disease or iinjury that initiated events Due to (or as a consequence of) resulting in death) Last Physician/Medical that the death certificate be Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?

1 Yes 2 No 9 Unknown 9 Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Division of Vital Records, 2 No 3 Probably 4 Unknown 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? autonsy 1 🗌 Yes 2 🗌 No 25. Was case referred to medical Hospital or Attending Physician: completed filled in by the funeral director, Be 26. Place of Death (Check only one) examiner? 2 W No 2 Other: 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence After this Certificate: 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural iniury work? 1 \sum Yes 2 \sum No 5 Pending Investigation
6 Could not be Accident Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) 24 hours Medical Ertifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. within 24 h To the Fur 🔲 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) cynthea Kuther-Sand, of March 31, 2011 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Wash, ngton County, Cynthia Kuther-Sands up Hospice of Washington 747 Northern Avenue 1- HC Maryland 21742 32. egistrar's Signature State Registrar

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Certificate of Death Registrar 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month FREDDIE JONES M. Medical Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death County of Death Examiner ISDUR comico 8. Date of Birth (Month, Day, Ye DEC. 5. If Under 1 Year If Under 24 Hrs 9. Birthplace (State or Foreign **Funeral** 1 **X**M 2 □ F Country) MARYLAND Director 221-22-3451 76 Usual Residence of Decedent show permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mertal Hygiene. Inmportant: If item 27 is marked other than "natural", or items 23a or 28a-f sho important: If item 27 is marked other than "natural", or items 23a or 28a-f sho any injury or other traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2X No MARYLAND WICOMICO WILLARDS 10f. Zip Code 10e, Street and Number 10g. Citizen of What Country? Funeral 8313 LITTLETON ROAD 21874 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status 14. Race - American Indian. Black, White, etc. þ ☐ Yes 2 X No Yes, Give 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 Yes 2 X No Specify: WHITE Completed 3 Widowed 4 Divorced Year or Dates 15. Decedent's Education 16a, Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) **FARMER** AGRICULTURE Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) FRANCIS JONES ANNIE DONOWAY 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) RUTH A. BRADFORD/DAUGHTER 7494 TRUITT ST., PITTSVILLE, MD 21850 20b. Place of Disposition (Name of cemetery, crematory or other place, 20a, Method of Disposition 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) DALE CEMETERY 3/29/11 WHALEYVILLE, MD Signature of Funeral Service Licer 22. Name and Address of Facility HASTINGS FUNERAL HOME, SELBYVILLE, DE complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest only one cause on each line. 23a, Part 1. Enter the disease, Part 1. Enter the disease, or conshock, or heart failure. List only Approximate Interval Between Immediate Cause (Final Onset and Death Physician/ stepe Medical resulting in death) Due to (or as a coas quence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Uisease or impury ne Due to (or as a consequence of) To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and Exam the burial-tran that initiated events Due to (or as a consequence of) resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 for use as IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) ____ in the past 12 months? Day Month Year 2 No been signed by the should be detached 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 🗌 No 3 Probably 4 ☐ Unknown page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 1 Yes 2 No Yes 2 completed filled in by the funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner?

1 Yes a √No Other: မ Other (Specify) Hoshi 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of be table 28c. Injury at work? 28d. Describe how injury occurred Certificate: 1 Natural 5 Pending 1 Yes 2 No Investigation 6 Could not be Accident 3 ☐ Suicide 4 ☐ Homicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 🗹 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a, Certifier (Check 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated only one) 29b. Signatule and title of dertifier 29c. License number 29d. Date signed (Month, Day, Year) 063199 26/11 andress of person who completed cause of death (Item 23a) (Type, Print) 30. Name and SALISBURY MD. DR

Registrar DHMH 17 Rev 7/2009

State

31. Date filed (Month, Day,

SHORE

EAST

32 Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene-State Registrar Certificate of Death Reg. No Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Physician/ 20, 2011 5:00 P M March. Walter Dewitt Lott Sr. Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Chestertown Kent Chester River Hospital Center If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign 6. Sex 1 XM 2 ☐ F **Funeral** Hours Months Min. 12/04/1917 New Jersey Director 93 143-03-8773 th and Mental Hygiene. 27 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Examiner must be notified at 10d. Inside City Limits 10b. County 10c, City, Town or Location within 72 hours after death with the Maryland 10a. State Director 1 Yes 2 No Queen Anne's Chestertown 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number Funeral <u>216</u>20 United States 236 Princess Anne Drive 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces?
1 Yes 2 No
If Yes, Give 14 Race - American Indian 11. Marital Status Black, White, etc. Completed by 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 X No Specify: 3 XWidowed 4 ☐ Divorced White Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) **Agriculture** Farmer Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) ပ္ Edna Thompson Lott Walter W. Lott permit. Page 1 and 2 should be Department of Health and Men Important: If item 27 is marke any injury or other traumatic 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 11490 Still Pond Road Worton, Maryland 21678 Nancy Greenwood / Daughter Baltimore. 20b. Place of Disposition (Name of cemetery, crematory or other place, 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State Chesapeake Cremation 03/22/2011 Stevensville, MD 4 Donation 5 Other (Specify) 22. Name and Address of Facility Fellows, Helfenbein & Newnam Funeral 130 Speer Road Chestertown, Maryland 23a. Part 1. Enter he disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Set and Death Immediate Cause (Final Ph sician/ Congestile disease or condition resulting in death) Medical Examiner Sequentially list conditions, Examine cause (Disease or iinjury burial-transit executed and that initiated events Due to (or as a consequence of): resulting in death) Last attending physician Physician/Medical The law requires that the death certificate be P.O. Box 68760 as the IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death use 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ ó in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year Pregnant at time of death by the detached Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by page 2 should be 2 No Records, 3 Probably 4 Unknown 24a. Was an 24b. Were autopsy findings available prior to completion of cause of has autopsy performed? death? 1 ☐ Yes 2 ☐ No certificate diseasa To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certific completed filled in by the funeral director, I Division of Vital 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Hospital Other: 1 Tyes opatient 2 ER/Outpatient 3 DOA မ 4 Nursing Home 5 Residence 6 Other (Specify) Manner of Death 28c. Injury at work? 1 ☐ Yes 2 ☐ No 28b. Time of 28a. Date of injury 28d. Describe how injury occurred Certificate: Hospital or Attending (Month, Day, Year) Natural 5 Pending M Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number determined City or Town, State) Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation in my entitle. | | Medical 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one) 29b. Signature and title of certifie 29d, Date signed (Month, Day, Year) D0051735 NO of person who completed cause of death (Item 23a) (Type, Print) 30. Name and address 6602 Church Hill Road Chestertown, Maryland 21620 Frederick Delboy M.D. 31. Date filed (Month State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene. Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ March 30, 2017 4:30am Hop Thi Luona Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** 10110 New Hampshire Avenue, #202 Silver Spring Montgomeru 5. Social Security Number If Under 1 Year | If Under 24 Hrs Birthplace (State or Foreign Country) 7. Age (In vrs. last birthday) 8. Date of Birth Funeral 1 □ M 2 🖔 F Days Months June 01. 1916 216-94-8535 China Director Usual Residence of Decedent iral", or items 23a or 28a-f show Examiner must be notified at 10a. State 10b. County 10d. Inside City Limits 10c. City, Town or Location Director 1 🗆 Yes 2 🗓 No Maryland Silver Spring Montaomeru 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? items 23a 10110 New Hampshire Avenue, #202 20903 U.S.A. 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No If Yes, Give Year or Dates. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 Yes 2 No Specify. "natural", Specify 3 X Widowed 4 Divorced Asian Completed injury or other traumatic event, the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) permit. Page 1 and 2 should be filed within 7. Department of Health and Mental Hygiene. Important: If item 27 is marked other than any injury or other traumatics. Elementary/Seconday (0-12) College (1-4 or 5+) Homemaker Own Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Cuu Tran Thi Luong 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Kenneth Leung - Son 13200 Rippling Brook Dr., Silver Spring, MD 20906 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Burial 2 ☐ Cremation 3 ☐ Removal from State 4 Danation 5 Other (Specify) 04/02/2011 | Silver Spring. MD Gate of Heaven Cem. 22. Name and Address of Facility Hines-Rinaldi Funeral Home, Inc. 21. Signature of Funeral Service Licensee MODICA 11800 New Hampshire Ave., Silver Spring, MD 20904 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between shock, or heart failure. List only one cause on each line Immediate Cause (Final disease or condition Onset and Death Physician/ Cerebrovascular Infarction Medical resulting in death) Due to (or as a consequence of Examine Atrial Fibrillation Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of) Examin sician and burial-transit that the death certificate be executed Cause (Disease or iinjury that initiated events Hypertension resulting in death) Last Due to (or as a consequence of) Physician/Medical IF FEMALE: f yes, outcome of pregnancy
Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months? Month Pregnant at time of death 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Chronic Renal Failure 2 🗓 No 3 🗆 Probably 4 🗀 Unknown page 2 should 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy performed? Yes 2 X No death? Hospital or Attending Physician: Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 K Residence 6 Other (Specify) 2 X No ပ္ 1 Inpatient 2 Inpatient 3 Inpatient 2 Inpatient 3 Inpatient 2 Inpatient 3 Inpatient 3 Inpatient 3 Inpatient 3 Inpatient 2 Inpa within 24 hours after death.

To the Funeral Director: After this completed filled in by the funeral or Certificate: 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred work? 1 X Natural 5 Pending iniury 2 No 2 Accident
3 Suicide Investigation 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined Medical 1 🗵 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 3 only one) 29b. Signature and title of certifie 29d. Date signed (Month, Day, Year) March 30, 2011 D54486

Registrar DHMH 17 Rev 7/2009

State

68760

Box (

Records,

Division of Vital

7505 New Hampshire Avenue, Suite 310, Takoma Park, MD 20912

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Huyanh Ton, M.D., 31. Date filed (Month, Day, Year)

MAR 3 1 2011

Hospital or Attending Physician: he law requires that the death certificate be executed Division or Vital Records, P.O. Box 68760,

Certification: To Be Completed by		pexia	contributing to death but not res	suiting in the underlyir	ig caus	e given in Part I.			o use contribute to the cause of death? 2 ☑No 3 ☐ Probably 4 ☐ Unkno			
	24a. Was an autopsy performed? 1											
	25. Was case refe	rred to medical	26. Place of Death (Check only one)									
	examiner? 1 ☐ Yes 2 ∑	C No	Hospital: 1 ☐ Inpatient 2 ☐]ER/Outpatient 3□	Home	ne 5 😾 Residence 6 □Other (Specify)						
	27. Manner of Dea 1 □ Natural 2 □ Accident	th 5 ☐ Pending investigatio	28a. Date of Injury (Month, Day Year)	28b. Time of fnjury	2 8 c.	Injury at Work? 1 ☐ Yes 2 ☐ No	28d.	28d. Describe how injury occurred				
	3 ☐ Suicide 4 ☐ Homicide	6 Could not b determined		nome, farm, street, fac ify)	28f.	28f. Location (Street and Number or Rural Route Number, City or Town, State)						
	29a. Certifier (Check only one)			e(s) and manner as stated. and place, and due to the cause(s)								
5 -	29b. Signature and	d title of certifier			29c. L	icense number		29d. [Date signed (Month, Day, Year)			

State Registrar

31. Date filed (Month, Day, Year)

22 Registrar's Signature 31 2011

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Konstantin Khludenev M.D.

D59013

15825 Shady Grove Rd.Rockville,Md 20850

March 28,2011

Registrar
DHMH 17 Rev 1/2001

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32. pgistrar's Signature

11110 Campus Rd., Suite 130, Hagerstown, MD

21742

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	Funeral Director		5. Social Security Number 134-14-3077 Usual Residence of Decedent	M 2 🔀 F 7. Age (in y	rs. last birthday) 89 Yrs.	Months	Days			15,	, 1921 New York							
e Maryland 28a-f shov notified at	Director	10a. State Maryland 10b. County Washingt 10e. Street and Number		. City, Town or L Hagerst	own	Code	<u> </u>	10d. Inside City Lin 1 ☐ Yes 2 🔀										
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9036	urs after de tural", or it al Examine		1 Never Married 2 🖺 Married 3 Widowed 4 Divorced	Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates.		1 🗌 Yes	2 🔀 No	Specify:	erto Rican, etc.		Specif		hite					
Baltimore, Maryland 21215-0036 permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	Completed by	15. Decedent's Edu (Specify only highest grad Elementary/Seconday (0-12)		(Give	edent's Usu e kind of wo DO NOT us memak	rk done d e retired)	ation luring most of v	working	1	her o								
yland	d be filed Mental Hy, arked oth aric event	To Be	17. Father's Name (First, Middle, Last) Robert Pett	us Robichau	Robichaux			18. Mother's		ne (First, Middle, Malden Surname) Emily Louise Dahnken								
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Baltimore,	it. Page 1 a rtment of F rtant: If ite njury or otl		20a. Method of Disposition 1 Burial 2 Cremation 3 4 Other (Specify)	Removal from State	ob. Place of Disp cemetery, cre agersto	wn Cr	emate		ri1 2 2011	F	lagers	town	, Maryland					
Ba	Depariment Depariment Impo any it	. !	21. Signature of fluneral Service Licenses 23a. Part 1. Enter the disease, or complete	l:	4	15 Ea	st Wi			lage	stown		eyland 21740 Approximate					
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. Box 68760	To the Hospital or Attending Physician: The law requires that the death certificate be within 24 hours after death. Nuthin 24 hours after death. To the Funeral Director, After this certificate has been signed by the attending physicis completed filled in by the funeral director, page 2 should be detached for use as the bur	Completed by Physician/Medical	nysician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☑ No 9 ☐ Unknown	3c. If yes, outcome of pre 1 Live Birth 2 4 Pregnant at time 9 Unknown	Fetal death 3	☐ Ectopic ☐ Other (s					23d. D	ate of de	ilive ry Day Year				
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			30. Name and address of person who co	mpleted cause of death (D. O. (Item 23a) (Type,	Print)	45	825	18 nama		04	-0	1-2-11					
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene, 1 - State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Physician/ 2011 ALBERTA HORTON 1911 1acch Medical 4a. Facility Name (if not institution, give street and number, 4b. City, Town, or Location of Death Examiner 4c. County of Death Hospital Memorial Easton 121 If Under 1 Year | If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign 7. Age (in vrs. last birthday) Funeral Carolina 1 □ M 2X X Hours Min. **Director** 57 Yrs 241-86-5686 /1953 24 Usual Residence of Decedent shov 10a. State 10b. County 10c. City, Town or Location notified at 10d. Inside City Limits Director 28a-f Federalsburg 1 Yes 2 X No Caroline MD 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? must be r Funeral 21632 United States 3439 Jefferson Pond Road 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, the Medical Examiner Black, White, etc. ö ģ 1 Never Married 2 X Married 1 Yes 2 No
If Yes, Give
Year or Dates. 21215-0036 1 ☐ Yes 2 X No Specify. Specify: 3 Widowed 4 Divorced Black Completed 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Il Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) Education Teacher 4 permit, Page 1 and 2 should be filed Department of Health and Mental Hy, Important: If item 27 is marked othe any injury or other traumorizance. Be other traumatic event, Baltimore, Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ္ Rosie Lee Howell Cassie Lee Horton 19a. Informant's Name/Relationship (Type, Print) Husband 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 21632 41 ber 3439 Jefferson Pond Rd.Federalsburg, Clarence A. Lewis, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 KBurial 2 Cremation 3 Removal from State 4/1/2011 Hurlock, MD MD 4 Donation 5 Other (Specify) Veterans Cem. Signature of Funeral Service Licenses 22. Name and Address of Facility Framptom Funeral Home, Federalsburg, MD 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause Immediate Cause (Final Onset and Death Ph_sician/ disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examiner Due to for as a consecuence of Cause (Disease or iinjury and that initiated events resulting in death) Last Due to (or as a consequence of) attending physician I for use as the buria Physician/Medical the Hospital or Attending Physician: The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 IF FEMALE: yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months? 1 ☐ Yes 2 ☐ No Month Pregnant at time of death Day Year by the Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy perform 2 🗆 No 1 Tes Yes 25. Was case referred to medical To Be 26. Place of Death (Check only one) 1 \(\text{Yes} 2 No 1 Inpatient 2 ER/Outpatient 3 DOA Other: within 24 hours after death.

To the Funeral Director: After this completed filled in by the funeral di 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28h Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending 1 Yes 2 No Accident Investigation Suicide
Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a Certifier ₃ 🗖 Ce tifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title 2011 person who completed cause of death (Item 23a) (Type, Print)

Registrar

	_	For State Registrar		State	of Maryl		artment of rtificate of			/lental Hy	/gien Reg. N	2U1	Apparenting 4 to 1	12133
Physician Medica		1. Decedent's Nam NELI	,	e, Last) AGATI	łA	MET2	ZER			2. Date of D March		ay 201	1 ^{Year}	3. Time of Death 8:20 P
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Funeral Director		5. Social Security Number 265–44−5569 6. Sex 1 □ M 2 🗓 F				rs. last birthday) 80 Yrs.	If Under 1 Year Months Days		er 24 Hrs. Min.	8. Date of B April D		930		place (State or Foreign Ltry) Land
aryland a-f show fied at	ector	Usual Residence of 10a. State Maryland	10b. County	derick	10c	. City, Town or Lo	lerick						1	10d. Inside City Limits
ith the Margaret 18 it be noti	ral Dir	10e. Street and Nur	nber Otter	Ave.			10f. Zip Code	1701			"	Citizen of W		ntry?
permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any rigury or other traumatic event, the Medical Examiner must be notified at once. To Be Completed by Funeral Director	≥	11. Marital Status 1 Never Marr 3 Widowed	ried 2 Ma	12. Was Dec Armed F 1 Yes If Yes, Gi Year or D		or in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 □ Yes 2 ☒ No Specify:				Black, White, etc. Specify: White			can Indian, etc. ite	
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nd 2 shou ealth and m 27 is rr		19a. Informant's Na Linda	Young	hip (Type, Print) / daughte	er	I .	ng Address (Stree Holter				-			Code) 1769
Page 1 annent of Hant of Hant: If ite	- 83	20a. Method of Disp 1 A Burial 2 4 Donation	Cremation	3 ☐ Removal fror Specify)	n State		osition (Name of matory or other place in the contract of the			Date 8/2011	1	Location - 0	-	own, State aryland
permit. Departr Imports any inji		21. Signature of Fu	neral Service	Belevi	son		2. Name and Addr .621 Opos							, P.A. 21702
bhysician and the burial-transit the burial-transit edical Examiner	edical Examiner	show, or heart failure. List only one cause on each line. Interval Betwoen the cause (Final Question of the cause of the												Approximate Interval Between Onset and Dear 12 Mo nth
ne death certificate the attending phy ched for use as th	by Physician/Med	IF FEMALE: 23b. Was decedent in the past 12 1 Yes 2 9 Unknown	months?		Birth 2 🗆 gnant at time	Fetal death 3	☐ Ectopic pregnar ☐ Other (s <i>pecify)</i> _	ncy				23d. Date Mon		ery Day Year
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sician; certific irector,	ge Re	25. Was case referred examiner?	ed to medical X No	Hospital:	· · · · ·		Ot	L	eath (Check only one) Nursing Home 5 Residence 6 Other (Specify)					
To the Hospital or Attending Physician: The law requires that the death certific within 24 hours after death. To the Funeral Director. After this certificate has been signed by the attending prompleted filled in by the funeral director, page 2 should be detached for use as Medical Certificate: To Be Completed by Physician/Medical		27. Manner of Death 1 📉 Natural 2 🔲 Accident	h 5 🗌 Pendi Invest	28a. Date (Moi igation		ER/Outpatie 28b. Time o injury	f 28c. Inju	ry at		28d, Describe				2
		2 Accident Investigation 3 Suicide 4 Homicide Could not be determined See. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) See. Place of Injury - At home, farm, street, factory, office City or Town, State)										r or Rurai	Route Number,	
the Hospi hin 24 hou the Funer npleted fill	Medical	(Check 2 only one) 3	Medical Certifyin	Nurse Practioner	sis of examin	ation and/or inves	tigation, in my opir death occurred at t	ion, death he time, da	occurred at ate and plac	t the time, date	and place he cause	e(s) and due e(s) and mar	to the ca nner as st	luse(s) and manner stat tated.
viti To		29b. Signature and title of vertifier 29c. License number 29d. Date signed (Month,										(Month,	Day, Year)	
8		Harpal S	ingh M		186	Thomas	Print) Johnson	Dr./	# 105	/Fred	eric	k, MD	217	02
State		 Date filed (Monta) 	th, Day, Year)		Registrar's Si	gnature _	1							

DHMH 17 Rev 7/2009

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygien ? State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ 2011 1:50 AM March LILLIAN VIOLA MARSHALL Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Frederick Frederick Memorial Hospital Frederick If Under 1 Year If Under 24 Hrs 8. Date of Birth (Month, Pay, Nov • Social Security Number 6. Sex 7. Age (In yrs. last birthday, 9. Birthplace (State or Foreign **Funeral** 1 🗆 M 2 🙀 F Months Days Hours Pennsylvania Director 91 213-16-1817 Usual Residence of Decedent 28a-f show permit, Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho any injury or other traumatic event, the Medical Examiner must be notified at 10a, State 10b. County 10c. City. Town or Location 10d. Inside City Limits Director 1x Yes 2 ☐ No Maryland Frederick Thurmont 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 616 East Main Street 21788 U.S.A. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status Was Decedent Ever in U.S. 14. Race - American Indian Armed Forces?

1 Yes 2 No Black, White, etc. þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2X No Specify: 3 X Widowed 4 Divorced Specify: Completed White 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Assembly Worker Moore Business Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Paul Crilley Mrytle Alexander 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Paula Garman / Daughter 103 Hammaker Street, Thurmont, MD 21788 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other place) ☐ Burial 2X Cremation 3 ☐ Removal from State 3/26/2011 4 Donation 5 Other (Specify Smithsburg Crematory Smithsburg, Maryland Signature of Funeral Service Lice ROBERT E. DAILEY & SON FUNERAL HOMES, P.A. 615 EAST MAIN STREET, THURMONT, MD 21788 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Physician/ Praymonta disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Pleural E FFUSIONS Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of) Hospital or Attending Physician: The law requires that the death certificate be executed COSUNASA that initiated events resulting in death) Last Due to (or as a consequence of) the burialnding physician Physician/Medical Box 68760 use as 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?

1 Yes 2 No
9 Unknown Month Day Year ate has been signed by the a page 2 should be detached P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ Division of Vital Records, 2 No 3 ☐ Probably 4 ☐ Unknown Completed 1 Yes 24b. Were autopsy findings available 24a. Was an autopsy performed prior to completion of cause of death? 1 Yes 2 No Be 25. Was case referred to medical 26. Place of Death (Check only one) Hospital Other: 4 \(\text{Nursing Home} \) 5 \(\text{Residence} \) 6 \(\text{Other} \) Other \(\text{Specify} \) 1 Yes 2 100 ဂ္ 1 Inpatient 2 ER/Outpatient 3 DOA After this 27. Manner of Death 28a. Date of injury 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred injury (Month, Day, Year) Natural 5 Pending after death. 1 Yes 2 No ☐ Accident ☐ Suicide Investigation the 6 Could not be To the Hospital or Atte within 24 hours after de To the Funeral Directo completed filled in by the Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical Ecritifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of D0063653 Morch 25,2011 west Seventy Street Frederich, Marylan 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 400 hawn 31. Date filed (Month, Day, Year) 32. Redistrar's Signature State 28 201 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiens Certificate of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ 45 losep 201 Medical Examiner 4a. Facility Name (if not institution, give street and number) 4c. County of Death rar If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Months Days Min. 09 25 1 € M 2 □ F Hours Country) Director 214-28-6209 80 WV Usual Residence of Decedent 28a-f shov 10b. County 10a, State 10c. City, Town or Location 10d. Inside City Limits Examiner must be notified at Director 1 Yes 2 No WV Blaine Mineral 6 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? **23a** Funeral 72 hours after death with 26717 255 E Main Street USA items Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S 11. Marital Status 14. Race - American Indian, Armed Forces 10 Completed by 1 Never Married 2 Married 1 Yes If Yes, Give 2 🗶 Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify Specify. marked other than "natural" 3 Widowed 4 Divorced White Year or Dates. other traumatic event, the Medical 15. Decedent's Education 16a Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) should be filed within and Mental Hygiene. correctional officer Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ၉ John Henry McCloud Jessie Belle Kirby Department of Health and Important: If item 27 is m. any injury or other *** 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Larry J. McCloud-son 2408 Alma Road, Baltimore, MD 21227 20a, Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 🔀 Burial 2 🗌 Cremation 3 🔲 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) IOOF Cemetery 4/3/2011 Elk Garden, WV 21. Signature of Funeral Service Licenses 22. Name and Address of Facility David A. Burdock Funeral Home P.A N. 2nd St Oakland, MD 21550 23a. Par 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line Immediate Cause (Final Physician yeur disease or condition Medical resulting in death) Due to (or as a conseque ce of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or impury that initiated events Due to (or as a consequence of) burial-transit that the death certificate be executed and Due to (or as a consequence of): resulting in death) Last attending physician for use as the buria Physician/Medical Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) in the past 12 months? Month Pregnant at time of death 2 No detached g Unknown 9 Unknown P.O. I ģ signed t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Records, The law requires 1 Yes 2 No 3 Probably 4 Unknown Completed page 2 should peen Were autopsy findings available prior to completion of cause of 24a. Was an has autopsy perform death? certificate 1 ☐ Yes 2 ☐ No of Vital To the Hospital or Attending Physician: 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: ၉ 1 Inpatient 2 ER/Outpatient 3 DOA Nursing Home 5 Residence 6 Other (Specify) eral Director: After this filled in by the funeral di 27. Manner of Death 28a. Date of injury 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred (Month, Day, Year) Natural 5 Pending Division death 1 Tes 2 🗌 No Investigation Could not be 3 Suicide 4 Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) within 24 hours after d

To the Funeral Direct

completed filled in by determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated only one) Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifie 29d. Date signed (Month State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ _28°-March 2033 M Mary Ellen Minster 2011 Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Silver Spring Holy Cross Hospital Montaomeru 5. Social Security Number If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign 6. Sex 7. Age (In vrs. last birthday 8. Date of Birth **Funeral** 1 □ M 2 🌂 F Months Hours Min. 83 Washington. DC Director 577-30-1177 Usual Residence of Decedent ral", or items 23a or 28a-f show Examiner must be notified at 10b. County 10a. State 10c. City, Town or Location 10d. Inside City Limits Director Maruland Silver Spring 1 Yes 2 X No Montgomery 10f. Zip Code 10g. Citizen of What Country? Funeral 72 hours after death with 10151 Sutherland Road 20901 U.S.A. 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian. 1 Never Married 2 Married "natural", or Completed by 1 Yes If Yes, Give Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: 3 Divorced 4 Divorced Caucasian Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Second be filed within 7. Important: If item 27 is marked other than any injuy or other traumatic event once. Elementary/Seconday (0-12) College (1-4 or 5+) Wife/Mother Homemaker Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Charles Eckloff Maru Reidu 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 10151 Sutherland Road, Silver Spring, Maryland20901 Edmund Albert Minster - Spouse 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place 1 🛛 Burlan 2 🗆 Cremation 3 🖵 Removal from State Parklawn Memorial Pk. 04/04/2011 | Rockville, Maryland 4 Donation 5 Other (Specify) 21. Signature of Fun and Service Licen are 22. Name and Address of Facility Hines-Rinaldi Funeral Home. Inc. M00709 11800 New Hampshire Ave., Silver Spring, MD 20904 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Physician/ Respiratory Failure disease or condition Medical resulting in death) Due to (or as a consequence of) **Examiner** Bilateral Pneumonia Sequentially list conditions, Due to (or as a consequence of, it any, reading to immediate cause. Enter Underlying Cause (Disease or iinjury for use as the burial-transit To the Hospital or Attending Physician: The law requires that the death certificate be executed Acute Renal Failure and that initiated events Due to (or as a consequence of): resulting in death) Last attending physician Physician/Medical Dementia Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) in the past 12 months? Month Pregnant at time of death 9 Unknown 9 Unknown signed by t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 2 No 3 Probably 4 Dunknown Were autopsy findings available prior to completion of cause of 24a. Was an has autopsy perform death? certificate 1 ☐ Yes 2 ☐ No Yes within 24 hours after death.

To the Funeral Director: After this certific. 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner?
1 \(\sum \) Yes 2 \(\frac{X}{2} \) No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 A Inpatient 2 -ER/Outpatient 3 DOA Certificate: To 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28c. Injury at 28b. Time of 28d. Describe how injury occurred 1 X Natural 5 Pending 1 ☐ Yes 2 ☐ No Investigation 6 Could not be Accident Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide Medical 🗷 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a, Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifie avica D66372 March 29, 2011 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 1500 Forest Glen Road, Silver Spring, Maryland 20910 Majid Rahmanian, M.D., 31. Date filed (Month, Day, Year) NAR 3 1 2011 State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State
Registra/AMFND#23bperMF, 4/1/11; brw, MoCo Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 03/26/2011 MARY ELIZABETH MATTHEWS 1438 Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death St. Mary's Hospital Leonardtown St. Mary's Social Security Number 7. Age (In yrs. last birthday) 87 yrs. If Under 1 Year If Under 24 Hrs. **Funeral** 8. Date of Birth 9. Birthplace (State or Foreign Days Min. 1 □ M 2 🔀 F Hours (Month, Day, Year) 2/09/1923 Country) Director 219-48-5866 MDUsual Residence of Decedent 28a-f shor 10a. State 10b. County 10c. City, Town or Location Examiner must be notified at 10d. Inside City Limits death with the Maryland Director MD St. Mary's Mechanicsville 1 XYes 2 ☐ No ō 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 23a Funeral 29966 Ronald Drive 20659 USA 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No
If Yes, Give 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, ō þ 1 Never Married 2 Married within 72 hours after Maryland 21215-0036 1 ☐ Yes 2 XNo Specify. "natural", Specify: Completed 3X Widowed 4 ☐ Divorced Black Year or Dates. the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) 2 should be filed within 72 | h and Mental Hygiene. 7 is marked other than "r (Give kind of work done of life. DO NOT use retired) during most of working Elementary/Seconday (0-12) College (1-4 or 5+) 9th Housewife other traumatic event, Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Pinkney W. Marbley Mamie Thurston permit. Page 1 and 2 should I Department of Health and Me Important: If item 27 is mark 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Ronald H. Matthews/son 29966 Ronald Drive, Mechanicsville, MD 20659 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cematery, crematory or other place) 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Denation 5 ☐ Other (Specify) injury or Good Hope UMC Cem. 04/04/11 Silver Spring, MD 21. Sign /v e of Funeral Ser 22, Name and Address of Facility Snowden Funeral Home any 246 N. Washington St, Rockville, MD 20850 23a. Part 1. Enter the disease, shock, or heart failure. Liscomplications that caused the death Approximate Interval Between Immediate Cause (Final disease or condition Physician/ Medical resulting in death) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine ending physician and or use as the burial-transit that the death certificate be executed Cause (Disease or iinjury that initiated events resulting in death) Last Due to (or as a consequence of): Completed by Physician/Medical Box 68760 the attending IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery Live Birth 2 - Fetal death 3 Ectopic pregnancy ō in the past 12 months?
1 ☐ Yes 2 🔀 No Month Pregnant at time of death 5 Other (specify) Day Year as been signed by the 2 should be detached 9 Unknown 9 Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? the Hospital or Attending Physician: The law requires Division of Vital Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown certificate has been 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy within 24 hours after death.

To the Funeral Director: After this certificate he completed filled in by the funeral director, page performed 1 🗌 Yes 2 🗎 No Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner's 2 No Other: 1 Tes မ 1 Inpatient 2 ER/Outpatient 3 🗆 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury 28b. Time of 28c. Injury at work? Certificate: 28d. Describe how injury occurred injury (Month, Day, Year) Natural 5 Pending 2 Accident 1 Yes 2 No Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Şignature and title 29d, Date signed (Month, Day, Year) ł 30. Name and address of person who completed cause of death (Item 31. Date filed (Month, Day, Year)
MAR 3 1 2011 Registrar's Sign State Registrar

DHMH 17 Rev 7/2009

natheurs

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State
Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Joyce E. Martin March 28 20 Year 19:48P M Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Prince George's Washington Ft. Washington Medical Center If Under 1 Year If Under 24 Hrs. 8. Date of Birth Birthplace (State or Foreign Country) DC Social Security Number 6. Sex . Age (In yrs. last birthday) **Funeral** ΦC (Month 69, Yea 9 4 6 1 🗆 M 2 🔀 Months Hours 579 58 8901 Director 64 Usual Residence of Decedent "natural", or items 23a or 28a-f show edical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Directo Prince George's Ft. Washington MD 1X Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral USA 20744 9906 Jacqueline Drive within 72 hours after death Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian. Armed Forces Black, White, etc. 1 Never Married 2 Married ģ ☐ Yes 2 🛛 No Specify.Black Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify: 3 🗌 Widowed 4 🕱 Divorced If Yes, Give Completed Year or Dates permit. Page 1 and 2 should be filed within 72 hour. Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natur any injury or other traumatic event, the Medical I 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Decedent's Education 16b. Kind of Business Industry e filed wn. r∗al Hygiene. rer than "r (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Dept. of Education Program Analyst 12th Be 18. Mother's Name (First, Middle, Maiden Surname)
Thelma Holt 17. Father's Name (First, Middle, Last) Thomas Ervin 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 9906 Jacqueline Dr.Ft.Washington,MD 20744 Karen W.Johnson/ Sister 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other p 20c. Location - City or Town, State Date 1 🛮 Burial 2 🗆 Cremation 3 🗆 Removal from State Resurrection Cem. 4/5/2011 Clinton, MD 4 Donation 5 Other (Specify) 22. Name and Address of Facility Briscoe-Tonic Funeral Home 21. Signature of Funeral Service Licensee 42294 Old Washington Rd.Waldorf,MD 20601 23a. Part 1. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure, List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final atherosclerosis Physician/ COCONARY disease or condition resulting in death) Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Litter Underlying Cause (Disease or iinjury that initiated events Due to (or as a consequence of): that the death certificate be executed and Due to (or as a consequence of): resulting in death) Last burialattending physician for use as the burial Physician/Medical Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery ☐ Ectopic pregnancy ☐ Other (specify) ____ in the past 12 months? Pregnant at time of death 4 Pregnant
9 Unknown 1 ☐ Yes 2 ☐ No 9 ☐ Unknown P.O. | ò Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by hypertension Division of Vital Records, Hospital or Attending Physician: The law requires 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 X Unknown been signature 24b. Were autopsy findings available prior to completion of cause of death? diabetes 24a. Was an has autopsy performed' certificate 1 Yes 2 No Yes 2 No To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certific completed filled in by the funeral director, Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 12 No မ 1 Inpatient 2 ER/Outpatient 3 IDOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural
2 Accident
3 Suicide
4 Homicide 5 Pending 1 Yes Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) Medical 1. Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated Certifying Nurse Practioner. To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year))00*0 55 6 9* 26 105 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Vu Tuan 11711 Ft.Washington,MD 20744 Livingston Rd 31. Date filed (Month, Day, Year) State APR 0 Registrar

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day **Physician** аМ April Elizabeth Mae MARTIN 2011 5:10 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City. Town, or Location of Death **Examiner** Hagerstown NMS Healthcare Washington Year If Under 24 Hrs.
Days Hours Min. 6. Sex 7. Age (In yrs. last birthday) If Under Social Security Number 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Months Days 1 M 2 X F 85 Director Dec. 1925 212-24-3634 Maryland Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene.
ant: If item 27 Is marked other than "natural", or Items 23a or 28a-f show ury or other traumatic event, the Medical Examiner must be notifiled at 10a. State 10c. City, Town or Location 10b. County 10d. Inside City Limits 1 ☐ Yes 2 No Director Maryland Washington Hagerstown 10e. Street and Number 10g. Citizen of What Country? Funeral 1749 Edgewood Hill Circle 21740 Apt. 101 <u>USA</u> 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. 1 Yes 2 X No
If Yes, Give
Year or Dates: 1 → Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No þ Specify: White 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 12 <u>Drawing Assistant</u> <u>Telephone Company</u> 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be ၉ Livis V. Martin Ruth Elizabeth Mowen 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Darla Herbold - Niece 517 Quarrier Court, Westminster, Maryland 21158 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State permit. Pages Department of I Important: If ite any injury or of 1 ☐ Burial 2 【Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Hagerstown Crematory 4/6/2011 Hagerstown, Maryland 21. Signatur Jameral Service Licensee 22. Name and Address of Facility Minnich Funeral Home 415 E. Wilson Blvd. Hagerstown, Maryland 21740 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or as a cons a ence of) Examiner Sequentially list conditions, cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consequence of Examine or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Day 5 Other (specify) 1 ☐ Yes 2 No 9 Unknown p Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? autopsy performed? Yes 2X No 1 ☐ Yes 2 ☐ No 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 1 ☐ Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA this 28a. Date of Injury (Month, Day Year) After t 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Natural 2 Accident Injury ospital c. 4 hours after dea. real Director: After 5 Pending 1 ☐ Yes 2 ☐ No investigation 3 Suicide 6 Could not be determined Place of injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours at To the Funeral C the Hospital 29a. Certifier 1🔏 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) ed cause of death (Item 23a) (Type, Print)

Registrar

DHMH 17 Rev 1/2001

31. Date filed (Month, Day,

Year)

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Marsht

14014

Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death . Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ 2 Day 20// 0/50 AM Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death Examiner 4b. City, Town, or Location of Death 6-C019 ES nto 1 mule HOSP/74 If Under 1 Year If Under 24 Hrs. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** 8. Date of Birth 1 🗆 M 2 🗶 F Oct. 16, Year 1965 Days Min. Months Hours Country) DC Director 578-04-6862 45 Usual Residence of Decedent 23a or 28a-f show permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any lajury or other traumatic event, the Medical Examiner must be notified at once. 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 X Yes 2 No District Heights Maryland Prince George's 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 2710 Crestwick Place 20747 United States 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian Armed Forces?

1 Yes 2 No Black, White, etc. 1 Never Married 2 Married þ Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: If Yes, Give Year or Dates Specify: Black Completed 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) 12th Bus Operator Private Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ဂ္ William Faircloth Jr. Betty Miller 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 20747 Ravondia Butler - Daughter 2710 Crestwick Place District Heights, Md. 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 \boxtimes Burial 2 \square Cremation 3 \square Removal from State cemetery, crematory or other place Brentwood, Maryland Ft. Lincoln 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Signature Funeral Service Licens Stewart Funeral Home, Inc. Benning Road NE Washington, DC . Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Interval Between Onset and Death shock, or heart failure. List only one cause on each line Immediate Cause (Final Physician disease or condition resulting in death) 125+2+C Medical Due to (or as a consequence of) Examiner 40005 Sequentially list conditions Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury Due to (or as a consequence of) * Hospital or Attending Physician: The law requires that the death certificate be executed 24 hours after death. use as the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of) been signed by the attending physician should be detached for use as the burial Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?
1 Yes 2 No Day Pregnant at time of death Month Year Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown Certificate: To Be Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? within 24 hours after death.

To the Funeral Director: After this certificate I completed filled in by the funeral director, pag 1 Yes 2 No 1 Yes 2 No 25. Was case referred to medical 26. Place of Death (Check only one) examiner? 2 - No Other: 1 Inpatient 2 ER/Outpatient 3 IDOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Mann of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred work? 1 Yes 2 No Natural 5 Pending Accident Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check To the within 2 only one 29b. Signature and title of certifie 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 60 7503 SUrra Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month 0700 Physician/ Mary Frances Morgan 2011 March Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Dorchester Chesapeake Woods Center Cambridge If Under 1 Year If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday, 8. Date of Birth (Month, Day, Birthplace (State or Foreign Country) **Funeral** Months Days 1 🗆 M 2 💢 Hours 219-12-3710 90 Director Usual Residence of Decedent item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at Director 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location filed within 72 hours after death with the Maryland East New Market Dorchester 1 X Yes 2 □ No MD 10g, Citizen of What Country? 10e. Street and Number 10f. Zip Code 21631 Funeral United States 1912 Academy St. Apt 106 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S 14. Race - American Indian Armed Forces Black, White, etc. 1 Yes 2 No þ 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2X No Specify White 43 - 45Specify: Completed 3 Widowed 4 Divorced Year or Dates 15 Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) permit. Page 1 and 2 should be filed within 72 Department of Health and Mental Hyglene. Important: If item 27 is marked other than 'any injury or other traumatic event, the Mer College (1-4 or 5+) Elementary/Seconday (0-12) Health Care Medical Transcription 12 Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Mary E. Gambrill 2 Joseph Hall Poyner 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code, 19a. Informant's Name/Relationship (Type, Print) 105 Liberty Rd., Federalsburg, MD 21632 Brice H. Morris/Nephew Baltimore, 20c. Location - City or Town, State 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Lubbock Cemetery 03/26/11 Lubbock, Texas Signature of Funeral Service Licensee 22. Name and Address of Facility Framptom Funeral Home, P.A. 216 N. Main St., Federalsburg, MD 21632 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line Onset and Death Immediate Cause (Final Physician COPD disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner CARCINOMA BL APPER Sequentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to for as a consequence of Exami Hospital or Attending Physician: The law requires that the death certificate be executed use as the burial-transi and that initiated events resulting in death) Last Due to (or as a consequence of) signed by the attending physician Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No Year þ Month Dav Pregnant at time of death 5 Other (specify) 9 Unknown detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by cate has been signed page 2 should be 1 Yes 2 No 3 Probably 4 Dunknown 24b. Were autopsy findings available 24a. Was an prior to completion of cause of death? autopsy performed? Yes 2 No 1 Yes 2 No certificate completed filled in by the funeral director, Be 25. Was case referred to medical 26. Place of Death (Check only one) Other: 2 🖪 No မ 1 Yes 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 I ER/Outpatient 3 DOA After this 28a. Date of injury (Month, Day, Year) 27. Manner of Deat 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred Certificate: 1 💆 Natural 5 Pending 1 Yes 2 No death. Accident Investigation 24 hours after deat Funeral Director: 6 Could not be Suicide 28f, Location (Street and Number or Rural Route Number, 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated within 2 To the I only one) 29b. Signature and title of certifier 29c, License number 29d. Date signed (Month, Day, Year) MD. D69234 3011 3 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) CAMBRIDGE MD 21613. JEEVAN 503 BYRN STREET ERRABOLU 31. Date filed (Month, Day, Year) 32. Registrar's Signatur State Registrar MAR 2

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene, State
Registrar M.S. 4/1/11 Kent Co. Certificate of Death Amended#8 Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death . 2011 Physician/ MARCH 26, 2:10 PM MARY I. PHILLIPS Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** KENT CHESTER RIVER MANOR CHESTERTOWN 9. Birthplace (State or Foreign If Under 1 Year If Under 24 Hrs 8. Date of Birth Funeral Social Security Number 7. Age (In vrs. last birthday) 1 □ M 2**X** F MARYLAND Director 219-29-3848 88 Usual Residence of Deceder permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once. 10d. Inside City Limits 10a. State 10b. County 10c. City. Town or Location Director 1 X Yes 2 No ROCK HALL KENT MD 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral UNITED STATES 5548 BOUNDARY AVENUE 21661 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No
If Yes, Give . Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian. Black, White, etc 1 Never Married 2 Married ð Baltimore, Maryland 21215-0036 1 ☐ Yes 2 XNo Specify. Specify: 3 X Widowed 4 □ Divorced Completed BLACK Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) OWN HOME HOMEMAKER 8 Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည MARY SISCO WALTER WICKES 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) BOX 1496 BLADENBORO, NORTH CAROLINA 28320 ANDREA PHILLIPS/ GRANDDAUGHTER P.O. 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 1 X Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) AARON'S CHAPEL CEMETERY 04/02/2011 ROCK HALL, MARYLAND 22. Name and Address of Facility
FELLOWS, HELFENBEIN & NEWNAM FUNERAL HOME,
130 SPEER ROAD CHESTERTOWN, MARYLAND 21620 21. Signature of Funeral Service Licenses t 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest. Interval Between Onset and Death 23a nock, or heart failure. List only one cause on each line Immediate Cause (Final Priysician. Alzheiners disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, it any, leaving to immediate cause. Enter Underlying Examine Due to (or as a consequence of): Hospital or Attending Physician: The law requires that the death certificate be executed the burial-transi-Cause (Disease or linjury that initiated events and Due to (or as a consequence of) resulting in death) Last attending physician Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death for use 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy5 ☐ Other (specify) ____ in the past 12 months? Month Day Year signed by the a Yes 2 No 9 Unknown g Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of 24a. Was an has autopsy performe page death? After this certificate 1 ☐ Yes 2 ☐ No 1 ☐ Yes 2 25. Was case referred to medical funeral director. Be 26. Place of Death (Check only one) examiner? Hospital 2 No Other မ 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: 5 Pending injury work 1 Natural after death. 1 ☐ Yes 2 ☐ No 2 Accident Investigation the 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide completed filled in by determined City or Town, State) 24 hours a Funeral I Medical Decrtifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifie Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check ertifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated within 2 only one) 29b. Signature and title certifie 29d. Date signed (Month, Day, Year) 8 MO D0051735 6 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) FREDERICK DELBOY M.D. 6602 CHURCH HILL ROAD CHESTERTOWN, MARYLAND 21620

State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiens Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Month Edgar Louis Powell 04 03 2011 6:05 D 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death 314 Deer Park Hotel Road Deer Park Garrett 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Hours Months Days 1⊠M 2□F 218-12-5117 87 05 1923 MD Usual Residence of Decedent 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits 1 MYes 2 □ No MD Garrett Deer Park 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 314 Deer Park Hotel Road 21550 USA 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 ∑Yes 2 □ No If Yes, Give Year or Dates: 1 Never Married 2 Married 1945 1 ☐ Yes 2 X No Specify: 3 X Widowed 4 ☐ Divorced White 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 12 miner coal 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Edgar Andrews Bessie Powell 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Denver Eichorn-grandson 805 L St, Mt. Lake Park, MD 21550 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 Surial 2 ☐ Cremation 3 ☐ Removal from State Deer Park Cemetery 4/6/2011 Deer Park, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility David A. Burdock Funeral Home, P.A. 21 N. 2nd St, Oakland, MD 21550 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) OBSTRUCTURE 425 Due to (or as a consequence of): AtheroscheRotic Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Bladdy conce Due to (or as a consequence of): 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 3 Ectopic pregnancy Month Day Year 5 ☐ Other (specify) 4□Pregnant at time of death ☐Yes 2☐No 9□Unknown 23e. Did tobacco use contribute to the cause of death? Yes 2 No 3 Probably 4 Unknown 24a. Was an autopsy

Physician /Medical Examiner

Department of Health and Menta Important: If item 27 Is marked any Injury or other traumatic evonce.

Pages 1

the death certificate be executed

P.O. Box 68760,

or Vital Records,

Division

certificate

Physician

/Medical

Examiner

Funeral

Director

show

"natural", or items 23a or 28a-f shovedical Examiner must be notified at

within 72 hours after

1 and 2 should be filed within 72 hours Health and Mental Hygiene.

Baltimore, Maryland 21215-0036

Director

Funeral

2

Completed

Be

2

Examine attending physician and for use as the burial-trar Physician/Medical ed by the been signed to should be deta 2 Completed cate has t Be 2 To the Hospital or Attending Phys within 24 hours after death.

To the Funeral Director: After this completely filled in by the funeral di Certification:

23b. Was decedent pregnant in the past 12 months? 9 Unknown

1 Tes

4 ☐ Homicide

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

performed? 1□ Yes 🐉 No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) ²√No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28b. Time of

28a. Date of Injury (Month, Day Year) 27. Manner of Death Natural Accident 5 Pending investigation 6 ☐ Could not be 3 ☐ Suicide

determined

1 ☐ Yes 2 ☐ No 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

28d. Describe how injury occurred

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signatur and title of certifie

29c. License number 30035

28c. Injury at Work?

29d. Date signed (Month, Day, Year)

Free Cause of death (Item 23a) (Type, Print)

AFR MD (827 MEMORIAL DRIVE OAKLAND MD 2.1550 30. Name and address of person wi 1. chter ONALD

or State Registrar

Medical

31. Date filed (Month, Day, Year) 32 Registrar's Signature

DHMH 17 Rev 1/2001

14

State Registrar 31. Date filed (Month, Day

Year)

32. Registrar's Signature

11-02647 Julio Alberto Quiroga

Pleas	State of Maryland / Denartment of Health and Mental Hydiene	I.
	State of Maryland / Department of Health and Mental Hygiene	1
Si.	Contificate of Dooth	

		1- For State Certifica Registrar	ate of Death	Reg.	No.								
Physicia ledical Exami		00220 11220200 (111100		2. Date of Death Month D April 7, 2011		3. Time of Death 0614 hrs							
)		Facility Name (if not institution, give street and number) Suburban Hospital	4b. City, Town, or Location of Death Bethesda		4c. County of Death Montgomery								
Funeral Director		5. Social Security Number 6. Sex 7. Age (In yrs. last birt 1 1 1 2 F 4 5		24Hrs. 8. Date of Birth (MM/DD/YYYY) 9. Birthplace (State or Min. March 24, 1966 Foreign Country) Boliv									
ru k		Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 1											
nd show a	'n	MD Montgomery R	ockville			1 Yes 2 No							
Maryla 288-f	Director	10e. Street and Number	10f. Zip Code	10g.	Citizen of What Coun	try?							
th the l		5440 Marinelli Road, Apt. 134	20852										
MD 21215-0036 1 2 should be filed within 72 hours after death with the Maryland th and Mental Hygiene. 27 is marked other than "natural", or items 23a or 28a-f shown it the Medical Examiner must be notified at once.	Funeral	11. Marital Status 1 Never Married 2 Married 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 No	13. Was Decedent of Hispanic Origin? (Sp If Yes, specify Cuban, Mexican, Puerto		14. Race - Americ White, etc.	an Indian, Black,							
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2121; vuld be fil Mental H marked	B	Alberto Enrique Quiroga 19a. Informant's Name/Relationship (Type, Print) 19t	Carmen D. Mailing Address (Street and Number or F	Julia An		Zin Cada)							
imore, MD 2 Pages 1 and 2 shoul ment of Health and N tant: If item 27 is m or other traumatic	입		440 Marinelli Road,										
	1		of Disposition (Name of cemetery, pory or other place)		Oc. Location - City or 1	own, State							
Baltimore, bernit. Pages 1 an Department of Hea important: If ites		4 Donation 5 Other Specify: Gate o	of Heaven Cemetery	pril 12 2011	Silver Sp	ring,MD							
Baltimo permit. Page Department o Important: injury or otl		21. Signature of Funeral Service Licensee	22. Name and Address of Facility Francis J. Collins 500 University Blvd	Funeral	Home Inc.								
Physician	\dashv	23a. Part i. Entry the disease, or complications that caused the leath. Do no	it enter the mode of dying, such as cardiac or	respiratory arrest,	shock, or heart	Approximate Interval							
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		or condition resulting in death) Due to (or as a consequence of):											
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760, ficate be exe g physician s the burial -	/Medi	IF FEMALE: 23c. If yes, outcome of pregnancy	-1 per me 8714 4 20	11 46	23d. Date of delivery								
		23b. Was decedent pregnant in the past 12 months?		ncy	Month Da	ay Year							
Box 68 le death certif the attending ted for use as	Physician	1 Yes 2 No 9 Unknown 9 Unknown	Other (Specify)										
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of Vital Records, of Physician: The law require this certificate has been a meral director, page 2 should the	Completed			autopsy performe	prior to co	empletion of cause of							
Vital Recysician: The his certificate director, page	ပ္မွ	25. Was case referred to medical	26.Place of Death (Check of	1 Yes 2 only one)	No 1 ✓ Yes	2 No							
Vita	To Be	examiner? 1 ✓ Yes 2 No Hospital: 1 Inpatient 2 ✓ ER/Ou		g Home 5 Re	sidence 6 Other:								
ding P. After	Ë	1 Natural 5 Pending (Month, Day, Year)	F 20 1 Yes 2 No	28d. Describe how Unknown									
Division ral or Attendi rs after death. al Director: /	licati	2 Accident Investigation 28e Place of Injury - At home fa	rm, street, factory, office building, etc.		et and Number or Run	al Route Number, City							
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Division of V To the Hospital or Attending Phy within 24 hours after death. To the Funeral Director: After th completely filled in by the funeral	edical (29a. Certifier (Check only one) Certifying Physician: To the best of my knowledge, dear one) Wedical Examiner: On the basis of examination and/or in											
To t To t	Med	and manner stated. 29b. Signature and title of certifier	29c. License number		9d. Date signed (Mon								
		Thursday M Nod TO	O.C.M.E. 001	WE A	pril 8, 2011								
	İ	30. Name and address of person who completed cause of death (Item 23a)	inos 444 Porr Chart Dellin	MD 04004									
	ate	Theodore M. King, Jr., MD. Assistant Medical Exami 31. Date filed (Month, Day, Year) 32. Registrar's Signature		;, IVIU 27201									
Regist		ABB 4 4 9044 6 # 4	harles.										

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend item 19a per fh. g915 5-19-11 sm State of Maryland / Department of Health and Mental Hygiene state
State
RegistrarAmend#25perMD, FCHD, 3/30/11, Leertificate of Death Rea. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Year Physician/ Month Dav 03 201 Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death **Examiner** If Under 24 Hrs. Age (In vrs. last birthday 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Months Min. Aug 25, 1959 1 K M 2 | F 51 Hours 579-86-6556 Mary Land Director Yrs Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "nother 10b. County 10d. Inside City Limits 10c. City, Town or Location Director Maryland Montgomery Damascus YXX Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 10123 Sheldrake Circle, Damascus 20872 USA 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 2. Was Decedent Ever in U.S. 14. Race - American Indian, 11. Marital Status Armed Forces Black, White, etc. Completed by 1 Never Married 2XXMarried Yes 21 No 1 Yes 2 No Specify: If Yes, Give Specify: white 3 Divorced Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Pools and Spas 12 Contractor Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 0 Richard Remson, Sr. Betty Allen 19a. IRJ Gart's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Rich A. Remson, Jr. - son 25905 Ridge Manor Drive, Damascus, Maryland 20872 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Date 1 Burial 2 KCremation 3 Removal from State 3-25-2011 Stauffer Crematory 4 ☐ Donation 5 ☐ Other (Specify) Frederick, Maryland 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Stauffer Funeral Home 1621 Opossumtown Pike, Frederick, Maryland 21702 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ a. Hemorrhagic.
Due to (or as a consequence of): Medical resulting in death) Examiner operati Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examiner attending physician and for use as the burial-transit Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or iinjury that initiated events resulting in death) Last Physician/Medical patitis Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Month Dav Pregnant at time of death 5 Other (specify) 4 ☐ Pregnant 9 ☐ Unknown signed by the a g Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by 2 No 3 ☐ Probably 4 ☐ Unknown 1 🗌 Yes Completed plnous been 24b. Were autopsy findings available prior to completion of cause of 24a. Was an ESL page 2 s autopsy this certificate 1 Yes 2 No ours after death.

eral Director: After this certific filled in by the funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No ည 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) . Manner of Death 28b. Time of Certificate: 28d. Describe how injury occurred 28c. Injury at iniury Natural 5 Pending work? 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined 124 hours a Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifie completed 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practice To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check within 2 To the I only one 29d. Date signed (Month, Day, Year) 29b. Signatu 29c. License number son who completed cause of death (Item 23a) (Type, Print) St Baltimore TNOREZ Day, Year) Date filed (Month, 32. Registrar's Signature State MAR Registrar Date Black

For Amend Items 25,127,28 Maryland Department of Death and Mental Hygiene Registrar Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. per Physician 05/06/11 cs 1. Decedent's Name (First, Middle, Last) 2. Date of Death 04 Month $\underline{20}1^{\text{Year}}$ Physician/ Day 04 20:12 Virginia Bowman Rice Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Garrett Garrett County Memorial Hospital 0akland 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign 6. Sex **Funeral** 08 07 1921 1 □ M 2 🗷 F Days Hours Min. Director 577-24-3701 Usual Residence of Decedent 28a-f show 10b County 10a. State 10c. City, Town or Location 10d. Inside City Limits Director must be notified 1 Yes 2 X No MD 0akland Garrett ō 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? 23a Funeral USA 377 Lower Penn Point Drive 21550 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 0 by 1 Never Married 2 Married 1 ☐ Yes 2 X No If Yes, Give 72 hours after Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify: "natural", Completed 3 K Widowed 4 □ Divorced White Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) alth and Mental Hygiene. 27 is marked other than r traumatic event, the Me College (1-4 or 5+) Elementary/Seconday (0-12) own home Homemaker Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည William H. Bowman Ruby C. Johnson permit. Page 1 and 2 should be Department of Health and Men Important: If item 27 is marke any injury or other traumatic once. 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 377 Lower Penn Pt Drive, Oakland, MD 21550 Joyce Jones-daughter 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 1 🗷 Burial 2 🗆 Cremation 3 🗆 Removal from State Garrett Co. Memorial Gardens 4 ☐ Donation 5 ☐ Other (Specify) Oakland, MD Signature of Funeral Service Licensee 22. Name and Address of Facility David A. Burdock Funeral Home P.A. 77/2 21 N. 2nd St, Oakland, MD 21550 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line Immediate Cause (Final disease or condition Ph sician/ neumonia Medical resulting in death) Due to (or as a consequence of) 3 days Examiner Sequentially list conditions, if any, leading to immediate Examine Due to (or as a consequence of): that the death certificate be executed the burial-transit Cause (Disease or linjury CERTIFICATION APPROVED that initiated events resulting in death) Last and Due to (or as a consequence of): attending physiciar Physician/Medical P.O. Box 68760 as IF FEMALE: use 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?

1 Yes 2 No ò Month Pregnant at time of death Day Year the detached 9 🗌 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ page 2 should be Frachre Records, 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performe 2 🗌 No Yes 2 No 1 🗌 Yes within 24 hours after death.

To the Funeral Director: After this certific, completed filled in by the funeral director, i Division of Vital Hospital or Attending Physician: 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital: 1 X Yes Other: မှ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred Natural 2 X Accident 5 Pending 3:00 1 Yes 2 X No Subject fell 04/01/2011 Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) **Home** 28f. Location (Street and Number or Rural Route Number, City or Town, State) 377 Lower Penn Point Dr., Oakland, MD Medical 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier 29c. License number Potresis Motel no MO D45071 04/04/2011 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Patricia B. Gotsch, M.D., 311 N 4th St, Oakland, MD 21550 31. Date filed (Month, Day, Year) APR 06 2011 Registrar

Amended Item 25

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Regina Mae Rafferty Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner WMHS Regional Medical Center Allegany Cumberland If Under 1 Year If Under 24 Hrs. 8. Date of Birth g. Birthplace (State or Foreign 5. Social Security Number 7. Age (In vrs. last birthday) **Funeral** (Month, Day, 1 □ M 2 🖺 F Days Hours Min. Country)
Maryland Months 82 214-34-1932 Director 1928 Usual Residence of Decedent ms 23a or 28a-f show must be notified at 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location Director 1 Yes 2 X No Grantsville MD Garrett 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral USA 21536 10951 National Pike 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) "natural", or item edical Exaπiner n Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, Black, White, etc. ģ 1 Never Married 2 Married 1 Yes 2 X No If Yes, Give Year or Dates. Baltimore, Maryland 21215-0036 within 72 hours after 1 ☐ Yes 2 🔀 No Specify: Completed 3 X Widowed 4 Divorced White Medical 16a. Decedent's Usual Occupation 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working filed within 72 al Hygiene. life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) traumatic event, the Textiles 10 Seamstress Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) and Mental P ည Matilda McKenzie Charles Warne 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1 and 2 s of Health a item 27 i 15558 P.O. Box 339, 134 Park Ave., Salisbury, PA R. Elaine Hutzell/Daughter 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place, 20c. Location - City or Town, State permit. Page 1 a Department of H Important: If ite any injury or ot 1 X Burial 2 Cremation 3 Removal from State Grantsville Cemetery April 5, 2011 Grantsville, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Newman Funeral Homes, P.A. 21. Signature of Funeral Service Licens P.O. Box 275, Grantsville, MD 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause or each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ neema disease or condition resulting in death) Medical Examiner eau Sequentially list conditions. if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of) sician and burial-transit Exami requires that the death certificate be executed Cause (Disease or liniury that initiated events resulting in death) Last Due to (or as a consequence of) attending physician for use as the buria Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) in the past 12 months?
1 Yes 2 No Day Year Pregnant at time of death signed by the a d be detached f a I Inknown g Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Diabetes Mellitur Type 11 1 Yes 2 No 3 Probably 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy has page 1 Yes 2 No certificate Yes or Attending Physician: 25. Was case referred to medical 26. Place of Death (Check only one) funeral director, Be examiner? Hospital Other: 2 X No 1 Tes ၉ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred 1 Natural injury work? 1 ☐ Yes 2 ☐ No 5 Pending thin 24 hours after death.

the Funeral Director: After properted filled in by the fur ☐ Accident Investigation 6 Could not be 3 ☐ Suicide 4 ☐ Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) Hospital Medical 29a. Certifier 🚾 rtifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. To the within 2 To the F only one 29b. Signature and title of certifier 29d. Date signed (Month. Dav. Year) MD 2/11 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DHMH 17 Rev 7/2009

State

Registrar

31. Date filed (Month, Day, Year)

APR 0 6 2011

Box 68760

P.O.

Records,

Division of Vital

21502

Huma Shakil, 625 Kent Ave., Cumberland, MD

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Robinson Medical 4a. Facility Name (if not institution, give street and numbe 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Washington Fahrney Keedy Home Nursing Boonsboro MI If Under 1 Year If Under 24 Hrs. 8. Date of Birth Social Security Number 9. Birthplace (State or Foreign **Funeral** 1 M 2 X F Months Hours Min. July 2, 1912 Maryland 98 218-34-3904 **Director** Usual Residence of Decedent 28a-f show 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits notified at Director 1 🗌 Yes 2 😾 No Maryland Washington Hagerstown 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ö Examiner must be 23a Funeral 9658 Old National Pike 21740 USA items 72 hours after death Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status 12. Was Decedent Ever in U.S 14. Race - American Indian, Armed Forces Black, White, etc. ō ģ 1 Never Married 2 Married ☐ Yes 2XXNo 21215-0036 1 ☐ Yes 2 X No Specify: White If Yes, Give Specify: "natural", Completed 3 X Widowed 4 □ Divorced Year or Dates traumatic event, the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Hygiene. College (1-4 or 5+) Elementary/Seconday (0-12) Blocker Ribbon Manufacturing 8 and Mental Hygie is marked other Be Page 1 and 2 should be filed vent of Health and Mental Hygant: If item 27 is marked oth 17. Father's Name (First, Middle, Last) Maryland 18. Mother's Name (First, Middle, Maiden Surname) Lloyd Weider Martin Lottie Luvene Hart 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) A.Camille Hendrickson - Daughter 9658 Old National Pike Hagerstown, MD 21740 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State permit, Page 1 a Department of I-Important: If ite any injury or ot 1 X Burial 2 Cremation 3 Remova 4 Donation 5 Other (Specify) Cedar Lawn Mem. Park: 04-05-2011 Hagerstown, Maryland 21. Signature of Fundral Service L 22. Name and Address of Facility Osborne Funeral Home, P. A 425 S.Conococheague St. Williamsport, MD 21795 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart fallure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Pnysician disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner + ension Sequentially list conditions cause. Enter Underlying Cause (Disease or linjury edis been signed by the attending physician and should be detached for use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical law requires that the death certificate be IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months?

1 Yes 2 No
9 Unknown 3 D Ectopic pregnancy Month Pregnant at time of death 5 Other (specify) 9 Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 2 No 3 Probably 4 Unknown Records, Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an cate has }; autopsy performe certificate 1 ☐ Yes 2 ☐ No Yes Division of Vital director, 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 2 0 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA ျ After this funeral 28a. Date of injury (Month, Day, Year) 28c. Injury at work? 1 ☐ Yes 27. Manner of Death 28b. Time of 28d. Describe how injury occurred e Hospital or Attending P n 24 hours after death. e Funeral Director: After the pleted filled in by the funera Certificate: 5 Pending 1 Natural injury 2 Accident
3 Suicide Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifier completed (Check within 24 only one) 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated the 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 0 R128088 Kate en Smith 12011 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Hagerstown, MD 21740 Kate Smith DH-3 31. Date filed (Month, Day, Year) 32. Degistrar's Signature State 2011 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Day 2011 Physician P^{M} April 2 6:00 Margaret Hulda Reed /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner 8. Date of Birth (Month, Day, Yea Caroline 1127 Market Street Denton If Under 1 Year | If Under 24 Hrs. Social Security Number 7. Age (In vrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Year! Months Days Hours 1 □ M 2 □XF 98 1912 Maryland **Director** 215-82-1968 Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene. 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County show d other than "natural", or items 23a or 28a-f shov event, the Medical Examinat must be notified at 1 ☐ Yes 2 🛣 No Director Denton Maryland Caroline 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number U.S.A. 21629 9811 Reed Road Funeral 12. Was Decedent Ever in U.S Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 ∐Yes 2 TXNo If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 □Yes 2 🕅 No Specify Specify: ģ White 3 XWidowed 4 ☐ Divorced Completed 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene Important: if tem 27 Is marked other than 'any injury or other traumatic event, tre Meany injury or other traumatic event. Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Family 11 H.S. Grad. 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Hulda Bertha Andrew Wilbert Perry Butler ဂ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a, Informant's Name/Relationship (Type, Print) 701 S. Second Street Denton, Maryland M. Marion Reed 20c. Location - City or Town, State Date 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 1 Burial 2 Cremation 3 Removal from State Denton, Maryland 4 □ Donation 5 □ Other (Specify) Denton Cemetery April 8, 2011 22. Name and Address of Facility 21. Signature of Funeral Service Licens Moore Funeral Home, P.A. Denton, Maryland 21629 12 South Second Street Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart fail one cause on each line Immediate Cause (Final disease or condition resulting in death) COIDHAN vear **Physician** /Medical Due to (or as a conseq ice of) Examiner Sequentially list conditions, Examiner Due to for as a consequence of cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last burial-tran Due to (or as a consequence of) led by the attending physician detached for use as the buria Physician/Medical If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month in the past 12 months? 5 ☐ Other (specify) 1 ☐Yes 2 ☐ No 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? sate has been signed page 2 should be det Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 2 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 Onknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 1 ☐ Yes 2 ☐ No 1 ☐Yes 2 No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home Residence 6 Other (Specify) 1 Tes 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 2 Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No 6 □ Could not be 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 Homicide

Hospital or Attending Physiclan: The law requires that the death certificate be executed 24 hours after death.
Funeral Director: After this certificate has been signed by the attending physician and Division of Vital Records, P.O. Box 68760, filled in by the funeral director, 1 24 hours a completely within 2.

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29a Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed Month, Day, Year) 29b. Signature and t 29c. License number

ORIGINAL

and address of pason who completed cause of death (Item 23a) (Type, Print)

RAH VUC/Moon 9/20 Marker Street Senton Mb 2/629

State Registrar

Medical

31. Date filed (Month, Day, Year)

APR 0 5 201

State Registrar DHMH 17 Rev 7/2009 31. Date filed (Month

strar's Signature

Som

Name and address of person who completed cause of death (Item 23a) (Type, Print)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene) For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death ^{Day}2<u>011</u> March Physician/ 29 6:00 A. [™] Richard John Super Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Frederick Frederick Sunrise Assisted Living If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Ye May 23, Social Security Number 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) **Funeral** Min. Months Hours Couptry) Iowa 485-18-1507 Director 85 Usual Residence of Decedent "natural", or items 23a or 28a-f show edical Examiner must be notified at 10a. State 10c. City, Town or Location 10d, Inside City Limits Director MD Frederick Frederick 1 🛚 Yes 2 🗆 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21702 990 Waterford Drive USA 72 hours after death Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status 12. Was Decedent Ever in U.S 14. Race - American Indian, Armed Forces? ģ 1 Never Married 2 X Married 2 No Maryland 21215-0036 1 ☐ Yes 2X☐ No Specify: 1946 White If Yes, Give Specify: Completed 3 Widowed 4 Divorced Year or Dates traumatic event, the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15 Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) and Mental Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) City Government Structural Engineer Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ဂ္ Charles B. Super Mary Walljasper 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 343 Ashley Drive, Shepherdstown, WV 25443 19a. Informant's Name/Relationship (Type, Print) permit. Page 1 and 2 st.
Department of Health an
Important: If item 27 is Neil Super - Son Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 🔀 Burial 2 🗆 Cremation 3 🗆 Removal from State St. Peters 4-4-2011 |Harpers Ferry, WV 4 ☐ Donation 5 ☐ Other (Specify) Signature of Funeral Service Licensee 22. Name and Address of Facility Eackles-Spencer Harpers Ferry, Funeral Home Norton Koh Harpers 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line. Immediate Cause (Final Preumonia Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Dementia Sequentially list conditions. Examine it any, leading to immediate cause. Enter Underlying Due to (or as a consequence or, To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director After this certificate has been signed by the attending physician and completed filled in by the Innerial director, page 2 should be detached for use as the burial-transit Cause (Disease or linjury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?

1 Yes 2 No
9 Unknown Month Year Pregnant at time of death 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown Were autopsy findings available prior to completion of cause of 24a. Was an autopsy performed death? 1 ☐ Yes 2 ☐ No 1 ☐ Yes 2 🕱 No 25. Was case referred to medical 26. Place of Death (Check only one) Be Hospital: Other: 4 Nursing Home 5 Residence 6 2 X No ဂ္ 1 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: 1 X Natural 5 Pending 1 Yes 2 No Accident
Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check 3 🖟 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifie 29c, License number 29d. Date signed (Month, Day, Year) 1 Schulen cano 29 1201 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Schuler Oak 31. Date filled (Month, Day, Year) State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene ? Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Catherine Loudell Schroyer **MARCH** 2011 7:38A.M Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death Boonsboro Reeder's Memorial Home Washington If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 ☐ M 2X F Months Days Hours 2/8/1918Country) 92 213-42-2053 Director Usual Residence of Decedent or 28a-f show notified at 10a. State 10c. City. Town or Location 10d. Inside City Limits Director Middletown MD Frederick 1 Yes 2X No 10e. Street and Number 10f. Zip Code ō 10g. Citizen of What Country? "natural", or items 23a o with 1 Funeral 21769 2526 Quebec School Rd. USA 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces? Black, White, etc. ð 1 Never Married 2X Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: White If Yes, Give Year or Dates 3 Widowed 4 Divorced Completed er than "natur , the Medical I 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) shoe co. machinist alth and Mental Hygien 27 is marked other the traumatic event, the Be 18. Mother's Name (First, Middle, Maiden Surname)
Goldie Mann 17. Father's Name (First, Middle, Last) ပ္ Homer Tritipoe Page 1 and 2 should be a ment of Health and Menta 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) $\,^{21}$ and) $\,^{2526}$ Quebec School Rd $_{ullet}$, Middletown, 19a. Informant's Name/Relationship (Type, Print) (Husband) Russell Schroyer Sr. Important: If item 27 any injury or other th once. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State ■ Byfial 2 □ Cremation 3 □ Removal from State Lutheran cemetery 4/1/2011 Middletown, 5 Other (specify) 4 Onation ²Domanddre of Farthompson Funeral H POB 18, Middletown, MD 21769 Envir the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, heart failure. List only one cause on each line. Approximate Onset and Death Immediate Cause (Final Physician/ 6 disease or condition Medical resulting in death) Examiner Esquentially list conditions, Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Due to (or as a consequence of) transit the Hospital or Attending Physician: The law requires that the death certificate be executed and Due to (or as a consequence of) resulting in death) Last the burialattending physician for use as the buria Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) in the past 12 months?

1 Yes 2 No
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To the Funeral Director; After this certificate has I completed filled in by the funeral director, page 2 s autopsy death? ☐ Yes 2 ☐ No Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital: 2 X NO Other: မ 1 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 4 Uursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) Manner of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred Natural 5 Pending injury work? 1 ☐ Yes 2 ☐ No Investigation Accident 6 Could not be Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Medical 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) Signatur 29d. Date signed (Month, Day, Year) 10063233 03 2011 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) SHAHID MAHMOOD, 580 NORTHERN AVENUE, HAGERSTOWN, MARYLAND 21742 301-733-4496 31. Date filed (Month, Day, Year) 32. Registrar's Signature Registrar

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ 20 TORIA Medical 4a. Facility Name (if not institution, give street and number, 4c. County of Death **Examiner** 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Ye 9. Birthplace (State or Foreign Birthp. Country) MD **Funeral** Months 1 □ M 2 🕱 F Hours Director 91 217-74-8984 1919 Usual Residence of Decedent If item 27 is marked other than "natural", or items 23a or 28a-f show or other traumatic event, the Medical Examiner must be notified at 10b. County 10c. City, Town or Location 10d. Inside City Limits 10a. State be filed within 72 hours after death with the Maryland Director 0akland 1 Yes 2 No MD Garrett 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral USA 21550 131 Highland Drive 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status 14. Race - American Indian, Black, White, etc 1 Never Married 2 Married Completed by 1 Yes If Yes, Give 2 X No Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify. Specify: White 3 X Widowed 4 Divorced Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Health and Mental Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) own home homemaker Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Lucretia Tichinel Meshac Harvey Page 1 and 2 should 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 122 Highland Drive, Oakland, MD 21550 Jean Spencer-daughter Department of Healt Important: If item 2 any injury or other 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Burial 2 ☐ Cremation 3 ☐ Removal from State 4/2/2011 Swanton, MD 4 ☐ Donation 5 ☐ Other (Specify) Zion Cemetery . Signature f uneral Service License 22. Name and Address of Facility David A. Burdock Funeral Home, P.A. 2nd St, Oakland, MD 21550 23a. Pag 1. Enter the disease, or complications that caused shock, or heart failure. List only one cause on each line. 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest Approximate Interval Between Immediate Cause (Final Onset and Death Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to for as a consequence on Hospital or Attending Physician: The law requires that the death certificate be executed ate has been signed by the attending physician and page 2 should be detached for use as the burial-tran that initiated events Due to (or as a consequence of) resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery Ectopic pregnancy in the past 12 months Month Year Pregnant at time of death 5 Other (specify) 2 No 9 Unknown g Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 🗌 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an After this certificate has autopsy performed? 1 ☐ Yes 2 ☐ No director, Be 25. Was case referred to medica 26. Place of Death (Check only one) examiner? 2 No 2 4 ☐ Nursing Home 5 Residence 6 ☐ Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA completed filled in by the funeral 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 5 Pending Natural work? 1 🔲 Yes 2 🗌 No Investigation 6 Could not be Accident within 24 hours after deat To the Funeral Director: 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier ause of death (Item 23a) (T Registrar's Signatur State Registrar

DHMH 17 Rev 7/2009

State

Box 68760

P.O.

31. Date filed (Month, Day, Year) APR 0 5 2011



DHMH 17 Rev 1/2001

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Certificate of Death Registrar 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ APRII Mabel Virginia SHANK 2011 8:50A.M Medical **Examiner** 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Reeders Memorial Home <u>Boonsboro</u> Washington Birthplace (State or Foreign Country) Social Security Number 7. Age (In yrs. last birthday) If Under 8. Date of Birth **Funeral** 1 🗆 M 2 😿 F (Month, Day, 1v 27Months Days Hours Min. Director 93 July 1917 <u> 214-78-1999</u> West Virginia Usual Residence of Decedent ral", or items 23a or 28a-f show Examiner must be notified at death with the Maryland 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 X Yes 2 No Maryland Washington Hagerstown 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 350 Ridge Avenue 21740 USA Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian Armed Forces?
1 ☐ Yes 2 🕅 No Black, White, etc. permit. Page 1 and 2 should be filed within 72 hours after c Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or any injury or other traumatic event, the Medical Examin onee. Completed by 1 Never Married 2 Married パと、 ンげAiv K、 //(A のビレ Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates ☐ Yes 2 X No Specify. White 3 X Widowed 4 Divorced Specify. 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) 9 0 <u>Homemaker</u> Her own home Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Hacket Hess Flora Cave 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Gloria D. Miller - Daughter 50 Ridge Avenue, Hagerstown, Maryland 21740 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 🛣 Burial 2 □ Cremation 3 □ Removal from Star 4 □ Donation 5 □ Other (Specify) Salem Ref. Ch. Cem. 4/6/2011 Hagerstown, Maryland Signature of Funeral Sery 22. Name and Address of Facility e Licens Minnich Funeral Home 10 415 E. Wilson Blvd. Hagerstown, Maryland 21740 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ STAGE END ONSTRUCTUE LUNG disease or condition MONAT Medica! resulting in death) Due to (or as a consequence of): **Examiner** DEBILITY MONTES Sequentially list conditions. Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of): PAILURE TO THRUE MONTLOT been signed by the attending physician and should be detached for use as the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery ☐ Ectopic pregnancy in the past 12 months?

1 Yes 2 No Pregnant at time of death Other (specify) Month Day Year 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an To the Hospital or Attending Physician: The law within 24 hours after death.

To the Funeral Director: After this certificate has I page 2 autopsy performed' 2 1 No Yes 2 No completed filled in by the funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 M Nursing Home 5 Residence 6 Other (Specify) ပ္ 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred Natural 5 Pending 1 🗌 Yes 2 No Accident Investigation Suicide Could not be 4 Homicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) Medical 1. certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifier (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one 29b. Signature and title of certifier 29d, Date signed (Month, Dav. Year) 4656 M

State Registrar

WH-1

LAPPANS ROAD, BOONSBORO, MARYLAND 21713

301-432-8470

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

20311

GHAZALA QADIR,

APR

31 Date filed (Month, Day, Yea

		•	For State Registrar	otato of Marylar	Се	rtificate of L	Death	,	Reg. No.			
	Physicia	n/	1. Decedent's Name (First, Middle, Las					2. Date of De		Year	3. Time of Death	
	Medic	al		Leroy STONEBR	EAKER,			April	01 2011 0		0250AM	
	Examin	er	4a. Facility Name (if not institution, give Meritus Medical			4b. City, Town, or Hager	r Location of Death		4c. County of Death Washington			
	Funeral Director		5. Social Security Number 6. Se	7. Age (In yrs.	last birthday) 73 Yrs.	If Under 1 Year Months Days		8. Date of Bir (Month, Da July 10		9. Birthp	lace (State or Foreign	
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	or 28	ă	10e. Street and Number		160136	10f. Zip Code		1	10g. Citizen of V	What Coun		
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020	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Mimportant: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	쥰	11. Marital Status 1 ☐ Never Married 2 🛣 Married 3 ☐ Widowed 4 ☐ Divorced	If Van Oille	959 I		Was Decedent of Hispanic Origin? (Specify Yes or I if Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 Yes 2 X No Specify:			e - America ck, White, e wh		
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No th	-	29b. Signature and title of certifier			29c. License	number		29d. Date sign	ned (Month, Da	ay, Year)
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		30. Name and address of person who		23a) (Type,	Print)	loune 1		T- 1-		MO 2170
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St	ate	31, Date filed (Month, Day, Year	1 4 2013. Registrar's Signat	ture	backer					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician Month Lu1a Beatrice Spicer March /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death 8. Date of Birth (Month, Day, Year) Oct. 28, 1 Under 24 Hy 5. Social Security Number If Unde **Funeral** 7. Age (In yrs. las Birthplace (State or Foreign Country) Months Days 1 □ M 2 🖸 F 246-09-3188 88 **Director** 1922 North Carolina Usual Residence of Decedent filed within 72 hours after death with the Maryland permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examination rust be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits MD Dorchester Be Completed by Funeral Director Cambridge 1 XYes 2 No 10e. Street and Number 10f. Zin Code 10g. Citizen of What Country? 711 Greenwood Avenue 21613 USA 12. Was Decedent Ever in U.S Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Race - American Indian, Black, White, etc. 1 ☐Yes 2 No If Yes, Give 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify black Specify: 3 XWidowed 4 ☐ Divorced Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) cafeteria worker public school 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Pages 1 and 2 should be 'nent of Health and Mental Clifton Haughton Rosa Daniels 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Gloria J. Spicer-Bouler daughter 711 Greenwood Ave., Cambridge, MD 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ☐ Burial 2 🙀 Cremation 3 ☐ Removal from State Crematory of Delmarva 4 Donation 5 Dother (Specify) 4/2/11 Delmar, DE 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Thomas Funeral Home P.A. 700 Locust St., Cambridge, MD 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (b) as a consequence of) The law requires that the death certificate be executed attending physician and for use as the burial-tran Division of Vital Records, P.O. Box 68760 Physician/Medical IF FEMALE yes, outcome of pregnancy 23b. Was decedent pregnant in the past 12 months?
1 ☐ Yes 2 ☐ No 23d. Date of delivery ☐ Live birth 2☐ Feta! death 3 Ectopic pregnancy Month signed by the ar 4 Pregnant at time of death Day Year 5 Other (specify) 9 Unknown 9 🗌 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ page 2 should be Be Completed 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? has 24a Was an autopsy performed? Yes 2 2 0 After this certificate 1 ☐ Yes 2 No Hospital or Attending Physician: funeral director, 25. Was case referred to medical 26. Place of Death (Check only one examiner? Certification: To 1 Yes 2 No Hospital: Other: 1 Inpatient 2 R/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending investigation Injury death. s after death. 1 ☐ Yes 2 No 2 Accident completely filled in by the 6 Could not be 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 24 hours 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) To the within 2 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 31. Date filed (Month, Day State Registrar

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death ^{Day} 2<u>011</u> Month Physician/ March 27 10:55 P ^M Tobler Judith Ann Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Frederick Ijamsville 9901 Wentworth Place 8. Date of Birth (Month, Day, Sept. 23 If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign Social Security Number 7. Age (In yrs. last birthday) **Funeral** Min. Year) 1961 Pennsylvania Months Hours 1 M 2 XF Director 49 528-96-9108 ral", or items 23a or 28a-f show Examiner must be notified at 10d. Inside City Limits filed within 72 hours after death with the Maryland 10a. State 10b. County 10c, City, Town or Location Director 1 🗆 Yes 2 No Ijamsville Frederick Maryland 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number United States 21754 9901 Wentworth Place 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No If Yes, Give 14. Race - American Indian, Black, White, etc. þ 1 Never Married 2 X Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: "natural", Completed 3 Widowed 4 Divorced White Year or Dates other traumatic event, the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) marked other than Elementary/Seconday (0-12) College (1-4 or 5+) Homemaker Own Home Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မှ Elizabeth Ann Johnson Frederick W. Cassell . Page 1 and 2 should iment of Health and M tant. If item 27 is ma 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 9901 Wentworth Place, Ijamsville, MD 21754 Rondal Tobler / Husband 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State permit. Page 1 Department of Important: If it any injury or o 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Stauffer Crematory 3/29/2011 Frederick, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Stauffer Funeral Home 21. Signature of Funeral Service License 1621 Opossumtown Pike, Frederick, MD 21702 23a. Pat 1. Inter the disease or complications the feathed the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. Ust only one cause on each line. ancreatic cancer Months - YEARS Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Due to (or so consequence of): Examiner Sequentially list conditions, Examiner Due to or as a consequence of): cause. Enter Underlying attending physician and I for use as the burial-transit Cause (Disease or iinjury that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical or Attending Physician: The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months?

1 Yes 2 XNo
9 Unknown Month Year igned by the atte be detached for Day 4 Pregnant 5 Other (specify) Pregnant at time of death signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 3 Probably 4 ☐ Unknown 1 ☐ Yes 2 ☐ No Completed plnods been 24b. Were autopsy findings available prior to completion of cause of 24a, Was an has autopsy perform Yes 2 1 ☐ Yes 2 ☐ No this certificate within 24 hours after death.

To the Funeral Director: After this certific completed filled in by the funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? 2 X No 1 🗌 Yes 4 Nursing Home 1 Inpatient 2 ER/Outpatient 3 DOA 5 Residence 6 Other (Specify) Certificate: To 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at work? 1 ☐ Yes 2 ☐ No 28d. Describe how injury occurred 1 Natural injury 5 Pending Investigation Could not be Accident 3 Suicide
4 Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined the Hospital Medical certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of

Registrar
DHMH 17 Rev 7/2009

46 B Thomas

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

MD

32 Registrar's Signature

TALMUR

31. Date filed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Certificate of Death Registrar 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day3 March Physician/ Khiennedy Tjing Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Frederick Frederick Frederick Memorial Hospital If Under 8. Date of Birth 9. Birthplace (State or Foreign 7. Age (In vrs. last birthday) Social Security Number (Month, Day, Year) **Funeral** Months Days Hours 1 X M 2 1 Indonesia Ĭ925 **Director** 185-78-6203 86 Usual Residence of Decedent ral", or items 23a or 28a-f show Examiner must be notified at 10d. Inside City Limits Page 1 and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene. ant: If item 27 is marked other than "natural", or items 23a or 28a-f sho 10c. City, Town or Location 10a. State 10b. County Director 1 X Yes 2 □ No Maryland Frederick Frederick 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number Funeral United States 21703 1128 Providence Court Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give 14. Race - American Indian. 11. Marital Status Black, White, etc. 1 Never Married 2 Married Completed by Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Specify: Asian 3 🗆 Widowed 4 🗆 Divorced Year or Dates traumatic event, the Medical 16a. Decedent's Usual Occupation 16b. Kind of Business Industry 15. Decedent's Education (Give kind of work done during most of working (Specify only highest grade completed) life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Jewelry Assembler Be 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) ပ Tjang Ho Tjan Ho 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 Department of Health Important: If item 27 any injury or other tr 3000 Fabus Court Kissimmee, Florida 34758 Shintia Miller / Daughter 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date March 27, 2011 1 Burial 2 Cremation 3 Removal from State Frederick, Maryland 4 Donation 5 Other (Specify) Stauffer Crematory 22. Name and Address of Facility 22. Name and Address of Facility Stauffer Funeral Homes, P.A. 1621 Opossumtown Pike Frederick, Maryland 21702 Si ature Funeral Service Licensee entos 23a. Part 1. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate
Interval Between
Onset and Death Immediate Cause (Final MEJMONIA Ph, ician/ Medical resulting in death) Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of): Cause (Disease or linjury To the Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events resulting in death) Last and burial-trar Due to (or as a consequence of): attending physician Physician/Medical Division of Vital Records, P.O. Box 68760 the IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live Birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant Ectopic pregnancy in the past 12 months?
1 Yes 2 No Day Month Year Pregnant at time of death Other (specify) signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 2 ☐ No 3 ☐ Probably 4 ☐ Unknown page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed' 1 Yes 2 No Yes 2 K No 25. Was case referred to medical 26. Place of Death (Check only one) within 24 hours after death.

To the Funeral Director: After this certific completed filled in by the funeral director, To Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Tyes 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? 1 ☐ Yes 2 ☐ No 27. Manner of Death 28d. Describe how injury occurred Certificate: injury 5 Pending Natural Accident Investigation Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Medical Ycertifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check 29d. Date signed (Month, Day, Year) 29b. Signatur d title of certifier 00062223 March 25, 2011 30 Name and address of person who completed cause of death (Item 23a) (Type, Print) TJDUJE, FREDERICE, MD 21702.

Registrar

DHMH 17 Rev 7/2009

State

31. Date filed (Month

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygieney For State Registrar 3/30/2011 M.S. Kent Co. Certificate of Death Amended #8 Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death MARCH 27^{Day} 2011^{Year} Physician/ 1:37 рм PATRICIA ELIZABETH TRAYNOR Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Cecil Elkton Union Hospital Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth aril 939 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday, **Funeral** Min. 1 M 2 F Hours Feb 9 Te Country) **Delaware** 72 Yrs. Director 221-24-4101 Usual Residence of Decedent 28a-f shov 10d. Inside City Limits 10a. State 10c. City, Town or Location with the Maryland Examiner must be notified at Director 1 Yes 2 XNo Cecil Elkton MD 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 23a or Funeral U.S.A. 21921 209 Appleton Rd. permit. Page 1 and 2 should be filed within 72 hours after death \text{Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items any injury or other traumatic event, the Medical Examiner mu Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status 12. Was Decedent Ever in U.S. Race - American Indian. Armed Forces Black, White, etc 1 ☐ Yes 2 🛣 No If Yes, Give ģ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🔀 No Specify: White Specify: Completed 3 Divorced 4 Divorced Year or Dates 16a. Decedent's Usual Occupation 15. Decedent's Education 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) State of Delaware Para-legal Secretary Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Mary Elizabeth Rydlewski Edward J. Turulski 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 209 Appleton Rd. Elkton, MD. 21921 (husband) William Traynor 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Burlal 2 🔀 Cremation 3 🗆 Removal from State Kent Cremation Services 3/29/10 Smyrna, DE. 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Galena Funeral Home of Stephen L. 118 West Cross St. Galena, MD. 21 of Funeral Service t 1. Ther the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, or heart failure. List only one cause on such line. Approximate bstructive Pulmonary Interval Between Immediate Cause (Final Onset and Death Physician disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury Examine Due to (or as a consequence of): To the Hospital or Attending Physician: The law requires that the death certificate be executed the attending physician and ned for use as the burial-tran that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No
9 Unknown Month Day Year Pregnant at time of death 5 Other (specify) 9 Unknown signed by t Id be detach Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ρ 1 Yes 2 □ No 3 □ Probably 4 □ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an s certificate has b director, page 2 s autopsy performed? 1 ☐ Yes 2 ☐ No Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 🗷 No 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA မ After this within 24 hours after death.

To the Funeral Director: After thi completed filled in by the funeral 28a. Date of injury (Month, Day, Year) 28c. Injury at work? Certificate: 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No Accident Investigation Suicide Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title certifier 29c. License number 3.28.2011. o completed cause of death (Item 23a) (Type, Print

Registrar

State

Elkan MD 21921.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death . 2<u>011</u> Physician/ Month Daniel A. Thomas March 24 0833 Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Prince George's Cheverly Prince George's Hospital Center Social Security Number 8. Date of Birth (Month, Day, Jan. 9, 9. Birthplace (State or Foreign 6. Sex 7. Age (In vrs. last birthday) If Under 1 Year If Under 24 Hrs. **Funeral** 1 🖾 M 2 🗆 F Days Hours Country) Maryland Director 218-30-4014 98 Jan. Usual Residence of Decedent show 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Page 1 and 2 should be filed within 72 hours after death with the Maryland Director 28a-f 1 🙀 Yes 2 □ No Prince George's Capitol Heights Maryland | 5 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 506 68th Street 20743 United States 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 11 Marital Status 14. Race - American Indian, Black, White, etc. 0. Completed by 1 Never Married 2 Married 2 🛛 No Baltimore, Maryland 21215-0036 1 Yes 2 X No Specify: Black If Yes, Give "natural", 3 X Widowed 4 Divorced Year or Dates marked other than "natur matic event, the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Mechanic Government 6th Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 Catherine Scotts Daniel Thomas 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <u>.s</u> Capitol Heights, Md. Dorothy E. Johnson - Daughter 506 68th Street item 2 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date Department of Important; If it cemetery, crematory or other place injury or 1 X Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) Landover, Maryland Harmony 22. Name and Address of Facility Stewart Funeral Home, Inc. 21. Signature of unit of Service Licenses any in once. the 20019 Benning Road NE Washington, DC 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Onset and Death Immediate Cause (Final CARSIAC h sician/ FATAL disease or condition Medical Examiner resulting in death) Due to (or as a consequence of) Sequentially list conditions Examine if any leading to inmedicause. Enter Underlying a consecuence of physician and the burial-transit Cause (Disease or iinjury that initiated events Due to (or as a consequence of) resulting in death) Last Physician/Medical law requires that the death certificate be P.O. Box 68760 attending pl IE FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
9 ☐ Unknown 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ 23d. Date of delivery in the past 12 months? Day Year Yes 2 No ed by the a 1 L Yes 2 L 9 Unknown certificate has been signed I rector, page 2 should be det Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Records, 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 1 Yes 2 No 2 🖊 No 25. Was case referred to medical Division of Vital Be 26. Place of Death (Check only one) Hospital Other: ပ္ 1 🗌 Yes 2 No 1 ☐ Inpatient 2 FR/Outpatient 3 ☐ DOA this 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify, te Hospital or Attending Pl 124 hours after death. e Funeral Director: After th 27. Manner of Death 28a. Date of injury 28b. Time of Certificate: 28c. Injury at work? 28d. Describe how injury occurred (Month, Day, Year) 1 🛮 Natural 5 Pending injury after death. 2 Accident
3 Suicide
4 Homicide 1 Yes 2 No Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 🗆 Certifying Nurse Practioner. To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifier D63688 30. Name and address of person v no completed cause of death (Item 23a) (Type, Print) 3001 GRIFFIN HOSPITAL CHEVERLY DAVIS 31. Date filed (Month, Day State

DHMH 17 Rev 7/2009

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 1 - For State Registrar State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Physician/ Edith Jones Taylor 9:40 AM 2011 April Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death **Examiner** Glen Burnie Anne Arundel Baltimore-Washington Med. Ctr. If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth 5. Social Security Number 7. Age (In yrs. last birthday) 6. Sex 9. Birthplace (State or Foreign Funeral (Month, Day, Year) 2C • 3, 1925 Hours 218-24-4578 85 S. Carolina Director Usual Residence of Decedent 28a-f show 10a. State 10b County 10c. City, Town or Location the Maryland 10d. Inside City Limits notified at Director Annapolis Anne Arundel 1 XYes 2 No MD 10e. Street and Number 10f. Zip Code 5 10g. Citizen of What Country? must be n Funeral 21401 Washington Apt. 29 W. United States death v Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14 Race - American Indian er than "natural", or iter the Medical Examiner Black, White, etc. ģ 1 Never Married 2 Married Yes 2 No Saltimore, Maryland 21215-0036 within 72 hours after If Yes, Give Year or Dates 1 ☐ Yes 2 ☑ No Specify: Specify: Black Completed 3 Widowed 4 ☐ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working should be filed within 72 h and Mental Hygiene.
7 is marked other than "r life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Food Processor Factory Worker Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ൧ Missouri Beckett Frank Jones permit. Page 1 and 2 should be Department of Health and Men Important: If item 27 is marke any injury or other traumatic traumatic 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 21060 19a. Informant's Name/Relationship (Type, Print) Dorothy T. Parsons/Daughter 7878 Americana Circle, Apt. 203, Glen Burnie, MD 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place, 1X Burial 2 Cremation 3 Removal from State Hurlock, Maryland 04/08/11 Fastern Sh. Veterans Cem. 4 Donation 5 Other (Specify) 22. Name and Address of Facility Framptom Funeral Home, P.A. 21. Signature of Funeral Service Licensee W 216 N. Main St., Federalsburg, MD 21632 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Onset and Death Immediate Cause (Final Physician/ ar sommers ra disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate Examine Due to (or as a consequence of): burial-transi Cause (Disease or linjury that initiated events resulting in death) Last and Due to (or as a consequence of): inding physician use as the burial Physician/Medical certificate be Box 68760 use yes, outcome of pregnancy
☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 🗌 Ectopic pregnancy atten for u in the past 12 months?
1 Yes 2 No 5 Other (specify) Month Day Year Pregnant at time of death the Unknown Unknown P.O. signed by the Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? <u>\$</u> Division of Vital Records, 1 Yes 2 No 3 Probably 4 Unknown Completed peen 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an ate has bage 2 s autopsy performed? Yes 2 No After this certificate Hospital or Attending Physician: 1
 24 hours after death.
 Funeral Director: After this certifica 25. Was case referred to medical examiner?
1 ☐ Yes 2 ☑ No funeral director, 26. Place of Death (Check only one) Be Other: 4 \square Nursing Home 5 \square Residence 6 \square Other (Specify) Hospital: ည 1 Inpatient 2 KER/Outpatient 3 IDOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at work? 1 □ Yes 2 □ No Certificate: 28d. Describe how injury occurred injury 1 Natural 5 Pending Accident
Suicide Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f, Location (Street and Number or Rural Route Number, þ 4 Homicide determined City or Town, State) filled in Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. completed Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check within 2 To the only one) 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month, Day, Year) 2 1061726 4,4,0011 WY mosses grumi

DHMH 17 Rev 7/2009

State

Registrar

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

31. Date filed (Month, Day, Year)

APR 08

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day 28, MARCH 2011 9:04 A Physician/ UMAPATI PURUSHOTTAM Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (if not institution, give street and number) Examiner MONTGOMERY SILVER SPRING HOLY CROSS HOSPITAL 9. Birthplace (State or Foreign If Under 1 Year | If Under 24 Hrs. 8. Date of Birth Age (In yrs. last birthday) Social Security Number Country)
INDIA **Funeral** (Month, Day, Yea FEB. 1. 1 Days Hours 1 X M 2 □ F 1936 75 Director 218-19-3758 Usual Residence of Decedent 10d. Inside City Limits shov 10b. County 10c. City, Town or Location 10a. State ral", or items 23a or 28a-f sho Examiner must be notified at the Maryland Director 1 😾 Yes 2 🗆 No SILVER SPRING MONTGOMERY MD. 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number Funeral Page 1 and 2 should be filed within 72 hours after death with: U.S.A. 20901 UNIVERSITY BLVD. W 321 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. 11 Marital Status Black, White, etc. Armed Forces?

1 Yes 2 No
If Yes, Give 1 Never Married 2 Married þ Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🔯 No Specify ASIAN INDIAN "natural", 3 Widowed 4 Divorced Completed Year or Dates 16b. Kind of Business Industry traumatic event, the Medical 16a. Decedent's Usual Occupation 15. Decedent's Education (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) I Hygiene. other than "I Elementary/Seconday (0-12) College (1-4 or 5+) INDIA MILITARY SENIOR FORMAN 18. Mother's Name (First, Middle, Maiden Surname) Be 17. Father's Name (First, Middle, Last) nd Mental I ၉ SANE INDUMATI UMAPATI SOLOMON PAUL 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) and l 19a. Informant's Name/Relationship (Type, Print) permit. Page 1 and 2 sh Department of Health ar Important: If item 27 is any injury or other trau UNIVERSITY BLVD. W, SILVER SPRING, MD. 20901 VIMAL UMAPATI/WIFE 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place, Date 20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State GEORGE WASHINGTON CEM. 4-1-2011 ADELPHI, MD. Donation 5 Other (Specify) 21. Signature of Funeral Service bicenses 22.Neme and Address of Facility CHAMBERS FUNERAL HOME & CREMATORIUM, P.A 5801 CLEVELAND AVE., RIVERDALE, MD. 207 M00091 Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Onset and De HOURS Immediate Cause (Final MYOCARDIAL INFARCTION Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner YEARS HYPERTENSION Sequentially list conditions Due to (or as a consequence of) if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Hospital or Attending Physician: The law requires that the death certificate be executed 24 hours after death.

Funeral Director: After this certificate has been signed by the attending physician and that initiated events Due to (or as a consequence of): resulting in death) Last burialphysician the burial Physician/Medical Box 68760 33 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23d Date of delivery use 3 Ectopic pregnancy
5 Other (specify) ___ 23b. Was decedent pregnant Month Day Year in the past 12 months? for Pregnant at time of death 2 No signed by the a 9 Unknown Division of Vital Records, P.O. 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by 1 Tes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy performed? Yes 2 X N page 2 death? 1 Yes 2 No 26. Place of Death (Check only one) 25. Was case referred to medical funeral director, Be examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 X ER/Outpatient 3 I DOA 2 XNo ြု 28b. Time of 28d. Describe how injury occurred 28c. Injury at 27. Manner of Death 28a. Date of injury Certificate: (Month, Day, Year) injury work? X Natural 5 Pending 2 🗆 No Accident Investigation Could not be completed filled in by the 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Suicide 4 Homicide determined 24 hours a Medical **Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check

State Registrar EDDIE

only one

29b. Signature and title of certifie

Name and address of person who completed cause of death (Item 23a) (Type, Print)

To the I within 2 To the I

29c. License number

D0064008

29d. Date signed (Month, Day, Year)

MARCH 28,

SILVER SPRING, MD.

2011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiens Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month 03/29/201 Physician/ 1410 М JANIS VANAGS Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Rockville Montgomery Shady Grove Adventist Hospital Birthplace (State or Foreign Country) If Under 1 Year If Under 24 Hrs. 8. Date of Birth Sex X□ M 2 □ F 7. Age (In vrs. last birthdav Funeral (Month, Day, Year) 12/17/1950 Hours Min. Germany Director 60 212-54-2302 Usual Residence of Decedent 28a-f show 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location Examiner must be notified at Director 1 X Yes 2 ☐ No MD Gaithersburg Montgomery 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ò Funeral 23a 507 D S. Frederick Avenue, #2 20877 **USA** items ? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, 11 Marital Status MARCH Armed Forces?

1 Yes 2 No Black, White, etc. 1X Never Married 2 Married "natural", or Completed by 21215-0036 1 ☐ Yes 2 X No Specify. If Yes, Give Specify: 3 Divorced 4 Divorced White Year or Dates permit. Page 1 and 2 should be filed within 72 hours Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natur any injury or other traumatic event, the Medical E 15 Decedent's Education 16a Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) King Pontiac GMC Lot Attendant 12th Be Baltimore, Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) VANAGS ပ Brunislays Vanags Marga Lange 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 9404 Bac Place, Gaithersburg, MD 20877 Nancy Stanton/sister ce of Disposition (Name of netery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 20b 1 Burial 2 Cremation 3 Removal from ANIS 4 Dogation 5 Other (Specify) Cremation Svc :04/01/11 Hanover, MD 21. Signature of Funeral Service Lice 22. Name and Address of Facility Snowden Funeral Home 246 N. Washington St, Rockville, MD 20850 23a. Part 1. Enter the disease, or corpolications that caused the deshock, or heart failure. List only one cause on each line. Do not enter the mode of dying, such as cardiac or respiratory arrest Approximate Interval Between Onset and Death Immediate Cause (Final 101-cphvit15 Physician/ e disease or condition resulting in death) Medical Die t (or as a consequence of): Examiner hours 6cp51 Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury that initiated events. Due to (or as a consequence of) transit requires that the death certificate be executed that initiated events resulting in death) Last and Due to (or as a consequence of) attending physician at for use as the burial. Physician/Medical P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant Ectopic pregnancy in the past 12 months?
1 Yes 2 No Month Year Day 5 Other (specify) Pregnant at time of death 1 Yes 2 9 Unknown signed by the a Linknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🖫 Unknown Records, Completed peen 24b. Were autopsy findings available prior to completion of cause of 24a. Was an Hospital or Attending Physician: The law page 2 has autopsy death? performe 1 Yes 2 No 1 Yes 2 No After this certificate 25. Was case referred to medica **Division of Vital** funeral director, 26. Place of Death (Check only one) Be examiner? Hospital 1 ☐ Yes 2 📈 No 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA ဂ္ 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: 1 🗹 Natural injury 5 Pending 1 Yes 2 🗌 No death. ☐ Accident Investigation 24 hours after death Funeral Director completed filled in by the 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical | Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifier (Check within 2. Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifie 70144 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Center Drive, Rockville, Mary Medical Mike Murray, MD 9901 31. Date filed (Mo State

Registrar

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	Funeral Director		5. Social Security Num 212-24-745	56	ex 7. Ag	e (In yrs. las 80	Ast birthday) Yrs. If Under 1 Year If Under 24 Hrs. Months Days Hours Min. Oct. 30,1930						9. Birthplace (State or Foreign Country) Arizona			
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Maryland	Id be Menta arkec atic e	유	Thomas E.	William	s Sr.				Helen F	isher						
Nar	shour and is m		19a. Informant's Nam				19b. Mailin	g Address (Stree	t and Number or Ru	ıral Route Numbe	r, City or Tow	n, State, Zip	Code)			
(1)	and 2 Health em 27 rther t		N. Marlee 20a. Method of Dispos		s/ Wife	T-01 01			Circle					702		
Baltimore,	permit. Page 1 and Department of Hea Important: If item any injury or other once.		1 🔲 Burial 2 🔀	Cremation 3	Removal from State	ce	metery, crem	sition (Name of natory or other pla		Date		on - City or T				
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5 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) GAFFAR SYED 80/ TOLL HousE AVE,									MAR	CH	27	20/1				
	5		30. Name and address	of person who c	ompleted cause of de	eath (Item 2	23a) (Type, Pi	rint)	HousE	AVE,	FRE	DERI	cK,	MD		
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State
Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death March 24, Day 011 Physician/ 2:50 WHITE CAROLYN NANCY Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Frederick Jefferson 4405 Canton Birthplace (State or Foreign Country)
 MD If Under 1 Year If Under 24 Hrs. 8. Date of Birth 5. Social Security Number 7. Age (In yrs. last birthday) Funeral Days Hours Months 1 □ M 2 🗓 F o*†\^&7?**9\\$7 MD Director 63 215-44-0271 Usual Residence of Decedent show or 28a-f shov notified at 10d, Inside City Limits 10a. State 10c. City, Town or Location with the Maryland Director 1 🗆 Yes 2 🌁 No MD Frederick Jefferson 10f. Zip Code 10g, Citizen of What Country? 10e Street and Number items 23a or ner must be r Funeral USA 4405 Canton Ave. 21755 death 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, "natural", or iten edical Examiner r 11. Marital Status Armed Forces? Black, White, etc. 1 Never Married 2 Married by Baltimore, Maryland 21215-0036 within 72 hours after 1 Yes 2 No Specify: If Yes, Give Year or Dates Specify: 3 Widowed 4 Divorced White Completed the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business Industry Page 1 and 2 should be filed within 73 ment of Health and Mental Hygiene. ant: If item 27 is marked other than ury or other traumatic event, the Me Elementary/Seconday (0-12) College (1-4 or 5+) Administrative Assistant communications 12 Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) ၉ Francis Spioch Homer Morrison Hinson 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 4405 Canton Ave., Jefferson, MD 21755 Richard White-husband 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Department of H Important: If ite any injury or ot once, 1 ☐ Burial 2 🖾 Cremation 3 ☐ Removal from State 3/24/2011 Frederick, MD 4 ☐ Donation 5 ☐ Other (Specify) Stauffer Crematory Signature of Funeral Service Licensee 22. Name and Address of Facility Stauffer Funeral Homes, P.A. 1621 Opossumtown Pike, Frederick, MD 21702 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart saidure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Pnysician/ Lung Cancer 12 months disease or condition resulting in death) Medical Due to (or as a c / sequence of) Examiner Sequentially list conditions. Examine if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of) ng physician and as the burial-transit The law requires that the death certificate be executed Cause (Disease or ilniury that initiated events Due to (or as a consequence of) resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death use 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ jo in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day Year Pregnant at time of death ned by the a Linknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? been signed t should be deta þ Morbid Obesity. 1 Yes 2 No 3 Probably 4 Unknown Completed Were autopsy findings available prior to completion of cause of COPD 24a, Was an has autopsy performe death? 1 Yes 2 No 1 Yes 2 No To the Hospital or Attending Physician: 25. Was case referred to medical 26. Place of Death (Check only one) funeral director, Be examiner? Hospital 2 No 1 Tyes 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 X Residence 6 Other (Specify) မ 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: within 24 hours after death.

To the Funeral Director: After to ompleted filled in by the funeral Natural work? 1 ☐ Yes 2 ☐ No 5 Pending Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month, Day, Year) DUD67691 03-24-2011 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Frederick, MD 21701

Registrar DHMH 17 Rev 7/2009

State

Mark G. Goldstein

31. Date filed (Month, Day, Year)

501 W7 +6 5+

Barke

32 Registrar's Signature

State of Maryland / Department of Health and Mental Hygien ? 1 - For State Registrar Certificate of Death I. Decedent's Name (First, Middle, Last) 2. Date of Death Month MARCH 2011 Physician/ 23 8:44A М LESLIE WACHTER EUGENE Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner FREDERICK FREDERICK MEMORIAL HOSPITAL FREDERICK 8. Date of Birth (Month, Day, Dec. 31 9. Birthplace (State or Foreign Country)
Maryland If Under 1 Year If Under 24 Hrs. Social Security Number Age (In yrs. last birthday, **Funeral** 1 👿 M 2 🗆 F 82 Hours Min. 212-24-5236 1928 **Director** Usual Residence of Decedent or 28a-f show notified at 10d. Inside City Limits 10a. State 10c. City, Town or Location filed within 72 hours after death with the Maryland Director 1 X Yes 2 □ No Frederick Frederick Maryland 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? ō "natural", or items 23a o United States 21701 Funeral 4 Catoctin Ave. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S 14. Race - American Indian, Arrived Forces?

1 Yes 2 1951-Black, White, etc. þ 1 Never Married 2 X Married 2 No Baltimore, Maryland 21215-0036 White 1953 1 ☐ Yes 2 🔀 No Specify: If Yes, Give Specify Completed 3 Widowed 4 Divorced Year or Dates er than "natur , the Medical I 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Page 1 and 2 should be filed within ment of Health and Mental Hygiene. US Government Maintenance & Operations permit. Page 1 and 2 should be filed wir Department of Health and Mental Hygie Important; If item 27 is marked other any injury or other traumatic event, ti Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 Margaret Carmack Leslie Drew Wachter 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Catoctin Ave., Frederick, MD 21701 Le Anaa Wachter / Daughter 20a. Method of Disposition
1

Marial 2 □ Cremation 3 □ Removal from State 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 4 ☐ Donation 5 ☐ Other (Specify) 3/28/2011 Frederick, Maryland Mt Olivet Cemetery Stauffer Funeral Home 21. Signature of Funeral Service Licenses 22. Name and Address of Facility 1621 Opossumtown Pike, Frederick, MD Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final Ph, i i.n/ disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions, Examine Due to for as a consequence of cause. Enter Underlying death certificate be executed burial-transi Cause (Disease or linjury and that initiated events resulting in death) Last Due to (or as a consequence of) attending physician I for use as the buria Physician/Medical P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Month Year Other (specify) Pregnant at time of death signed by the aid be detached for 9 Unknown Unknown Hospital or Attending Physician; The law requires that the Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by Records, 3 Probably 4 Unknown Completed should peen 24b. Were autopsy findings available prior to completion of cause of 24a. Was an page 2 s has autopsy performed Yes 2 No 1 ☐ Yes 2 ☐ No certificate 25. Was case referred to medical examiner?

1 Yes 2 No Division of Vital 26. Place of Death (Check only one) director, Be 1 Inpatient 2 K ER/Outpatient 3 I DOA 2 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) this 27. Manne at Leath 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: After work? injury Natural 5 Pending hin 24 hours after death.

the Funeral Director: A'
mpleted filled in by the fu Accident Investigation 6 Could not be 3 Suicide
4 Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical ectifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. within 2 To the F only one) 29b. Signature and title of certifier . License number 10+1 30. Name and address of person who completed cau egistrar's Signatur State a encolone Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

				State of Maryla								
		-	For State Registrar		Cer	tificate of L	Death	T	g. No U	12111		
	Physicia Medic		Decedent's Name (First, Middle, Last) Marion James Wilke	rson, Jr.				2. Date of Death Month March 18,		3. Time of Death 7:21 a M		
	Examin		4a. Facility Name (if not institution, give st				Location of Death		4c. County of D			
·			Washington Adventi		. last birthday)	Takoma	Park If Under 24 Hrs.	8. Date of Birth	Montgo	mery Birthplace (State or Foreign		
	Funeral Director			M 2 □ F	76 Yrs.	Months Days	Hours Min.	(Month, Day,) November	/ear)	Country) MD		
	aryland a-f show fied at	Funeral Director	10a. State 10b. County		City, Town or Lo	cation				10d. Inside City Limits 1 ☐ Yes 2 🔼 No		
	he Ma or 28 e noti	ä	MD Calvert 10e. Street and Number	!	Lusby	10f. Zip Code		10	10g. Citizen of What Coun			
	with 1 23a ust b	era	2001 Vine Street			20657			USA			
36	e filed within 72 hours after death with the Maryland tal Hygiene. ed other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at.	<u>م</u>		2. Was Decedent Ever in Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates.		Was Decedent of H If Yes, specify Cuba 1 Yes 2 No	an, Mexican, Puerto	ecify Yes or No- o Rican, etc.)		American Indian, Vhite, etc.		
9	hours natura ical E	Completed	15. Decedent's Edu	cation	16a. Deced	dent's Usual Occup	ation	1	16b. Kind of Busin	2701011		
215	n 72 an "r Med	티	(Specify only highest grad	e completed) College (1-4 or 5+)	(Give life. D	kind of work done of O NOT use retired)	_	king				
2	Hygiene. Other than ent, the N		Elementary/Seconday (0-12)	,		Pi <u>r</u>	be Layer		Pipe Layir	ng		
Maryland 21215-0036	id be filed Mental Hyg arked oth atic event	To Be	17. Father's Name (First, Middle, Last) Marion Wilkerson				Annie C					
	1 and 2 should be file if Health and Mental H item 27 is marked o other traumatic eve		19a. Informant's Name/Relationship (Typ					ox 786, Lus				
Baltimore,	age 1 an ent of He nt: If iten y or oth		20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ F 4 ☐ Donation 5 ☐ Other (Specify)	Removal from State	cemetery, crer	osition (Name of matory or other place Jones Cem	etery Marc		20c. Location - Cit Chesapeal	y or Town, State ke Beach, MD		
Baltir	permit. Page 1 s Department of H Important: If ite any injury or ot	l s	21. Signature of Funeral Service License			2. Name and Addre	ss of Facility S	ewell Funera , Prince Fre	l Home, P.A			
l,	100000		23a. Part 1. Enter the disease, or compl shock, or heart failure. List only on Immediate Cause (Final	cause on each line.		er the mode of dyir	ng, such as cardiac	or respiratory arres		Approximate Interval Between Onset and Death		
	mysician/ Medical Examiner		disease or condition resulting in death)	Due to (or as a cons	equence of):	-10109 1) ISEMIC					
	LAGITIMIE	ē	Sequentially list conditions,	DIABET								
	uted nd ransit	Examiner	if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events	CHRONI	C REW	AL FA	ILURE					
0	be executed sician and burial-transi	<u></u>	resulting in death) Last	Due to (or as a cons	equence of):							
Box 68760	ath certificate be executed attending physician and for use as the burial-transit	Physician/Medic	23b. was decedent pregnant	3c. If yes, outcome of pred 1 □ Live Birth 2 □ F		Ectopic pregnan	cv		23d. Date of			
. Bo	he death y the atte iched for	hysicia	in the past 12 months? 1 ☐ Yes 2 ☐ No g ☐ Unknown	4 Pregnant at time 9 Unknown		Other (specify)			Month	Day Year		
ls, P.O.	uires that the dea n signed by the a ild be detached f	ed by P	Part II. Other significant conditions co	ntributing to death but not	resulting in the	underlying cause g	iven in Part I.			te to the cause of death? Probably 4 Unknown		
Division of Vital Records,	The law require cate has been si page 2 should	Completed by						24a. Was ar autops perform 1 Yes 2	y prio	e autopsy findings available r to completion of cause of th? Yes 2 No		
a	sician: T certifica irector, p	Be C	25. Was case referred to medical examiner?				lace of Death (Che					
Ζ	Physical this ce	P	1 Yes 2 No	ospital: 1 Inpatient 2		nt 3 ∐ DOA	ner: 4 Nursing H	lome 5 🗆 Reside	nce 6 Other (Specify)		
on of	nding Ph ath. r: After thi		27. Manner of Death 1 Natural 5 Pending 2 Accident Investigation	28a. Date of injury (Month, Day, Year,	28b. Time o injury	wor	ry at k?] Yes 2 ☐ No	28d. Describe ho	w injury occurred			
FEMALE: 23c. If yes, outcome of pregnancy 1 Live Birth 2 Fetal death 3 Ectopic pregnancy 1 Live Birth 2 Live Bir									reet and Number o , State)	r Rural Route Number,		
_	To the Hospital or vaithin 24 hours after To the Funeral Directory	Medical	Check 2 Medical Examin	cian: To the best of my kn er: On the basis of examina Practioner: To the best o	ation and/or inves	stigation, in my opin	ion, death occurred	at the time, date an	d place, and due to	the cause(s) and manner stated.		
	To the complete compl	2	29b. Signature and title of certifier			29c. Licens	se number	2	9d. Date signed (A	Month, Day, Year)		
7	N A		30. Name and address of person who continued to the second	mpleted cause of death (I	tem 23a) (Type,	Print) CARROL	L AVEN	UE TAN	COMA Pr	TRK, MARYLAND		
O	Sta Registi		31. Date filed (Month, Day, Year)	32. Registrar & Sig	onature	for d.	P	(ARK, MARYLANI		

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Day Lorramo Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Prince Frederick Calvert Calvert Memorial Hospital 5. Social Security Number 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth **Funeral** (Month, Day, Year) Mary I and 1 □ M 2 🏋 F Months Days Hours Min. 579-36-3694 Director Mav Usual Residence of Decedent 1 and 2 should be filed within 72 hours after death with the Maryland f Health and Mental Hygiene.
File and Mental Hygiene.
To smarked other than "natural", or items 23a or 28a-f show deper traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 X No Calvert Owings 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 8609 Solomons Island Road 20736 U.S.A. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian 11. Marital Status Armed Forces?

1 Yes 2 No Black, White, etc. 1 Never Married 2 Married δ Maryland 21215-0036 1 ☐ Yes 2 X No Specify: If Yes, Give Year or Dates Completed white 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16h Kind of Business Industry College (1-4 or 5+) Elementary/Seconday (0-12) secretary School Board Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) ၉ Joseph Wilson Fowler Lula Grace 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Robin S. Phipps, daughter 6051 Franklin Gibson Rd.. Tracy's Landing, MD 20779 Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State ŧ ortant: If it injury or o 1 Burial 2 X Cremation 3 Removal from State permit. Page Department o Important: If any injury or once. 4 Donation 5 Other (Specify) Metropolitan Crematory 03/23/2011 Alexandria. VA 22. Name and Address of Facility Rausch Funeral Home, P.A. Signature of Funeral Service Lice is 8325 Mt. Harmony Lane, Owings, MD 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heaft failule. List only one cause on each line. Interval Between Immediate Cause (Final Onset and Death Physician/ In Massive disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Due to (or as a consequence of): attending physician and for use as the burial-transit requires that the death certificate be executed resulting in death) Last Due to (or as a consequence of): Physician/Medical Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death
9 Unknown 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months? Month Day as been signed by the 9 Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Records, 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an 1988; CL Hospital or Attending Physician: The law autonsy page perform 1 ☐ Yes 2 ☐ No 25. Was case referred to medical Division of Vital Be 26. Place of Death (Check only one) 2 No Other: 4 M Nursing Home 5 Residence 6 Other (Specify) 1 Yes ပ 1 Inpatient 2 I ER/Outpatient 3 I DOA After this 28a. Date of injury (Month, Day, Year) 28b. Time of 27. Manner of Death 28c. Injury at Certificate: 28d. Describe how injury occurred 1 🛛 Natural 5 Pending injury work? 1 ☐ Yes 2 ☐ No Accident Investigation 6 Could not be the 3 Suicide 4 Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, completed filled in by determined City or Town, State) To the Hospital of within 24 hours a To the Funeral D Medical 29a. Certifier 1 🕰 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 20061783 2011 30. Name and address of person who complete cause of death (Item 23a) (Type, Print) JRW 10 Prince Frederick, mo Chang Choi restruspita 31. Date filed (Mooth, Day, Year) 32. Registra State Registrar

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygien ? For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Physician/ AUSTIN WEIST 7:20 PM 2011 Apri. Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Loyalton of Hagerstown Washington County Hagerstown If Under 1 Year | If Under 24 Hrs.
Months | Days | Hours | Min. 9. Birthplace (State or Foreign . Social Security Number 8. Date of Birth 7. Age (In vrs. last birthday **Funeral** Illinois 1 □**X**M 2 □ F 185-09-9546 97 Director Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once. 10b. County 10c. City. Town or Location 10d. Inside City Limits Director 1 🗌 Yes 2 💢 No Maryland Washington County Hagerstown 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number Funeral 20009 Rosebank Way 21742 U.S.A. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status 12. Was Decedent Ever in U.S. Was Decedent Ever III Armed Forces? 1 X Yes 2 No If Yes, Give 1941 Year or Dates 1945 Black, White, etc. 1 Never Married 2 Married Completed by Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify. White 3 X Widowed 4 ☐ Divorced 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Contracto Self Employed Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) John Bernard Weist Edna Bunnell Weist 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Jacqueline Konkus-daughter 17116 Chiswell Rd. Poolesville. MD 20837 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State ☐ Burial 2X Cremation 3 ☐ Removal from State Smithsburg Crematory 4-6-2011 Smithsburg, MD 4 ☐ Donation 5 ☐ Other (Specify) Signature of Funeral Service Licensee 22. Name and Address of Facility Douglas A. Fiery Funeral Home 1331 Eastern Blvd. North Hagerstown, MD 21742 Part 1. Enter the disease, of complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final CEREBROVASCULAR ACCIDENT/STROKE Physician/ PYAG disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner YEARS ATHEROSCLEROTIC CARDIOVASCULAR DISEASE Squeritally liet conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury Due to (or as a consequence of) or Attending Physician: The law requires that the death certificate be executed been signed by the attending physician and should be detached for use as the burial-transi that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months?
1 ☐ Yes 2 ☐ No Day Month Year Pregnant at time of death 4 ☐ Pregnant 9 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 2 ☐ No 3 X Probably 4 ☐ Unknown HONE 1 🗌 Yes Completed 24b. Were autopsy findings available prior to completion of cause of 24a. Was an this certificate has autopsy performe death? 1 ☐ Yes 2 ☐ No 26. Place of Death (Check only one) Be 25. Was case referred to medical filled in by the funeral director, examiner? Other: 4 \(\sum \) Nursing Home 5 \(\mathbf{X}\) Residence 6 \(\sum \) Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA Certificate: To 1 Tes 28a. Date of injury (Month, Day, Year) 28c. Injury at work?
1 ☐ Yes 2 ☐ No Manner of Death 28b. Time of 28d. Describe how injury occurred To the Hospital or Attending F within 24 hours after death. To the Funeral Director: After 1 Natural 5 Pending Investigation Accident Suicide 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. completed only one) 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature D58810 APOIL 5, 2011 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) HAGERSTOWN MD 21742 STEVEN BLASH MD 12916 CONAMAR DR. SUITE 204 31. Date filed (Month, Pay Year) 2011 egistrar's Signature State Registrar

Baltimore, Maryland 21215-0036 Division of Vital Records, P.O. Box 68760

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	-	For State			State o	f Ma	arylan						lental Hy	/gien	e O O		10	171.
		Registrar 1. Decedent's Name	(First Middle	e. Last)				C	ertifica	te of L	Jeatn		2. Date of D	Reg. N	(g. U	1000	3. Time	of Death
Physicia		BARBARA A											Month MARCH		ay 201	1 ^{Year}		50 AM
Medic Examin		4a. Facility Name (if			et and num	ber)			4b, City	, Town, or	Location	of Death		4	c. County	of Death		
·- <u>-</u>		312 FAIR		6 Sev		7 Age	(In uro In	st birthda		ESTER er 1 Year		er 24 Hrs.	8. Date of B		(UEEN	ANN		or Foreign
Funeral Director		261–58–2		1 \(\text{N} \)	И 2 Х F	7. Age		1 Yrs	Months		Hours	Min.	06/13	/193	9. Birthplace (State or Foreign Country) WASHINGTON, DC			
od #	_	Usual Residence of 10a. State	Decedent 10b, County				10c. City	. Town or	Location								10d. Inside	City Limits
larylar 3a-f st iffied	Director	MD	OUEEN	ANNE	et s		10c. City, Town or Location CHESTERTOWN											es 2 XNo
the National and Second		10e. Street and Num		2111111						p Code				10g. C	Citizen of	What Cou	intry?	
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be filed within 72 hours after death with the Maryland ental Hygiene. ked other than "natural", or items 23a or 28a-f show ic event, the Medical Examiner must be notified at	by Fu	11. Marital Status 1 □ Never Married 2 ★ Married 12. Was Decede Armed Force 1 □ Yes 2				ces?). 1	If Yes, spe	cify Cuba	ın, Mexica	an, Puerto	ecify Yes or No Rican, etc.)	-	14. Race - American Indian, Black, White, etc.			
urs afte ural", I Exar		3 ☐ Widowed 4 ☐ Divorced If Yes, Give Year or Dates					1 ☐ Yes 2 🕅 No Specify:								Specify	WHI	TE	
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uld be d Meni marke natic	Ĕ	RICHARD						T					HERINE					
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1 and of Hea item		20a. Method of Disp	osition				20b. P	lace of Dis	position (Na rematory or	me of			Date	T			Town, State	<u> </u>
Page ment tant: It		1 🔀 Burial 2 [4 🗌 Donation			moval from	State	1	-	EMETE!			03/25	5/2011	H	JRLOC	CK, M	ARYLA	ND
permit. Page 1 and 2 should be filed within 72 hours Department of Health and Mental Hygiene. Important: If item 27 is marked other than "naturany injury or other traumatic event, the Medical once.		21. Signature of Fur	neral Service	Licensee	11		· · ·	5	22. Name a	IND Addres	ss of Faci	NEBIN	N & NEW	ŅAM	FUNI	ERAL	HOME,	P.A.
		23a. Part 1. Enter t	he disease, o	r complica	at 1s that c	aused	the death								IAKII	UNA	Approxim	ate
Physician/		shock, or hear Immediate Cause (I disease or conditio	Final	only one c	ause on ead A	ch line.		ar à a	Dura	D	NO 1	+ 1.0	Ac es				Interval B Onset and	
Medical Examiner		resulting in death)	11	a	Due to (orasa	consequ	ence of):	oma		Val		70 9					
	e.	Sequentially list con	nditions,	b	Due to (or ac a	consequ	ioneo ofi:		-								
ted I Insit	Examiner	if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury that initiated events c.																
(a) FE (c)	_	resulting in death) L		С	Due to (or as a	consequ	ence of):										
law requires that the death certificate beings been signed by the attending physicies should be detached for use as the burners.	Completed by Physician/Medica			d			-											
attending p	Ĭ,	IF FEMALE: 23b. Was decedent	pregnant	23c	. If yes, out										23d. Da	ate of deli	verv	
death e	sicia	in the past 12 months? 1								onth	Day	Year						
requires that the de been signed by the should be detached	Phy	9 Unknown Part II. Other signif	icant conditi	ons contri			it not resi	ultina in th	e underlying	cause giv	ven in Par	rt I.	23e Did	tobacco	use con	tribute to	the cause of	death?
res tha	d b	_			_			-									obably 4	
v requi	lete	TOBACC	0 10	1	111	-	1227		4			11/10	24a. Wa		24b.		opsy finding	
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sician: The la certificate ha irector, page 2	8 B	25. Was case referre examiner?	ed to medical				777 14	/		26. Pl	ace of De	ath (Check						
Physi this c	욘	1 Yes 2 2	No No	Inos	pital: 1 🔲 l 28a. Date d			ER/Outpa 28b. Time	tient 3 🗆 [Othe 28c. Injun	4 🗆 [ome 5 Res 28d. Describe				fy)	_
Attending Physician: The sr death. sctor: After this certificate by the funeral director, page	Certificate:	1 ☑ Natural 2 ☐ Accident	5 🗌 Pendi	ng igation	(Mont	h, Day,	Year)	injur		work		_	zou. Describe	now inju	ary occur	icu		
r Atte ter dea rector	ertif	3 ☐ Suicide 4 ☐ Homicide	6 Could determ				ry - At ho . (Specify,		street, facto	ry, office			28f. Location City or To			er or Rur	al Route Nur	mber,
To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certific completed filled in by the funeral director,	<u>g</u>	OCO Continue d	Ø Camitai	a Dhuai-i					h near read -	t the time	dota	d place a	nd due to the o			or so st-	ted .	
e Hos 124 hc e Fun	ledical	(Check 2	☐ Medical	Examiner:	On the basi	is of ex	amination	and/or inv	estigation, in	n my opinio	on, death	occurred at	t the time, date be, and due to	and plac	ce, and du	ue to the c	ause(s) and r	nanner stated
To th withir To th	Σ	29b. Signature and			0 0				29	c. License	e number			29d. D	ate signe	d (Month	Day, Year)	
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Rm		30. Name and address			pleted caus			23a) (Type	e, Print) Z 3 //	de	Stree	+ 1	Hen Si	ton	n.	ued	2/62	· c
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Registra	r		MAK	2 1	1111	14.	-	4	LE COL	Silvery or and								

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month 0136 AM Medical 4a. Facility Name (if not institution, give street and number) Town, or Location of Death 4c, County of Death **Examiner** nester town tai If Under 24 Hrs. 7. Age (In yrs. last birthday) If Under 1 Year 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Months 1 X M 2 □ F 04/11/1932 MARYLAND Yrs. Director 218-28-9601 78 Usual Residence of Decedent "natural", or items 23a or 28a-f show edical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 XNo CHESTERTOWN MD QUEEN ANNE'S 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? Funeral UNITED STATES 117 HILLSIDE ROAD 21620 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-11. Marital Status Race - American Indian. rmed Forces If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. 1 Never Married 2 X Married X Yes þ 2 No Baltimore, Maryland 21215-0036 within 72 hours after If Yes, Give Year or Dates. 1952–1956 1 ☐ Yes 2 X No Specify: 3 Widowed 4 Divorced Completed WHITE 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working th and Mental Hygiene. 27 is marked other than ' traumatic event, the Me life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) **TELECOMMUNICATIONS** LINEMAN Be permit. Page 1 and 2 should be filed Department of Health and Mental Hy Important: If item 27 is marked oth any injury or other traumatic event once. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ ALBERT YOOS LILLIAN HARTLOVE 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 117 HILLSIDE ROAD CHESTERTOWN, MARYLAND 21620 FRANCES YOOS / WIFE 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 Donation 5 Other (Specify) CRUMPTON CEMETERY CRUMPTON, MARYLAND 03/26/2011 22. Name and Address of Facility
FELLOWS, HELFENBEIN & NEWNAM FUNERAL
130 SPEER ROAD CHESTERTOWN, MARYLAND Signature of Euneral Service License Kik 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final Physician/ Meogradia Inflelier disease or condition resulting in death) Medical equence of) Examiner Spee Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Examiner Due to (or as a consequence of) that the death certificate be executed attending physician and for use as the burial-transit that initiated events resulting in death) Last Due to (o s a consequence of) Physician/Medical Box 68760 s, outcome of pregnancy
Live Birth 2 Petal death 3 Ectopic pregnancy

5 Other (specify) IF FEMALE 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day Year ate has been signed by the a page 2 should be detached to P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? δ Division of Vital Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Jinknown Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of autopsy performed Yes 2 death? After this certificate To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifica director, 25. Was case referred to medical Be 26. Place of Death (Check only one, examiner? Other: 2 No. မ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) the funeral 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred Matural Natural 5 Pending 1 Yes 2 No Accident Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, completed filled in by 4 Homicide determined City or Town, State) Medical 1 Kar Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title 29c. License number 30. Name and address completed cause of death (Item 23a) (Type, Print) LesTerlaun BROWN & 100 HIRRINEZ, Se.D. JOSE 31. Date filed (Month, Day, Year) State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Aracely Nohemi Maldonado Zepeda 2011 20P MARCH Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner SAINT JOSEPH MEDICAL CENTER BALTIMORE TOWSON 9. Birthplace (State or Foreign 5. Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth 6. Sex Age (In vrs. last birthday **Funeral** 29 Months Days Hours Min 4/13/1981 1 M 2 X Honduras none Director Usual Residence of Decedent shov 10b County 10c. City, Town or Location 10d. Inside City Limits 10a. State at with the Maryland Director ems 23a or 28a-f sh r must be notified a MD Baltimore Towson 1 🗆 Yes 2 🎽 No 10e. Street and Number 10f. Zip Code 10a, Citizen of What Country? 21204 Honduras Funeral 921 Southerly Road Apt.3 iral", or items 'Examiner mus death 1 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 X No If Yes, Give Year or Dates. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Race - American Indian. 11 Marital Status Black White, etc. þ 1 Never Married 2 Married pernit. Page 1 and 2 should be filed within 72 hours after of Department of Health and Mental Hygiene. Important; If item 27 is marked other than "natural", or any injury or other traumatic event, the Medical Examin Baltimore, Maryland 21215-0036 1

Yes 2

No Specify: Honduran White Completed 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation
(Give kind of work done during most of working 16b. Kind of Business Industry 15. Decedent's Education (Specify only highest grade completed) DO NOT use retired) Homemaker Elementary/Seconday (0-12) College (1-4 or 5+) Own Home Be 18. Mother's Name (First, Middle, Maiden Surname)
Emeralda Zepeda Vasquez 17. Father's Name (First, Middle, Last) ပ္ Andres Maldonado Sosa 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
921 Southerly Road Apt. 3 Towson, Md 21204 19a. Informant's Name/Relationship Companion/ Angel Evelio Martinez Luna 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place)

Jardin Memorial 20c. Location - City or Town, State Siguatepeque, Date Department of Important: If it any injury or o once. ■ Burial 2 ☐ Cremation 3
 Removal from State 4/04/2011 4 ☐ Donation 5 ☐ Other (Specify) **Honduras** Signal of Funeral Service Livense PHILIPADS RINALDI FUNERAL SERVICE, P.A. 9241 Columbia Blvd.Silver Spring, Md20910 nuce 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between MONTHS Immediate Cause (Final PULMONARY HYPERTENSION Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Examine Due to (or as a consequence of) To the Hospital or Attending Physician: The law requires that the death certificate be executed and the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of) attending physician Physician/Medical Division of Vital Records, P.O. Box 68760 use as 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant Ectopic pregnancy in the past 12 months?
1 Yes 2 No for Month Year 5 Other (specify) Pregnant at time of death signed by the aid Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ **ASTHMA** 1 ☐ Yes 2 XNo 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1X Yes 2 □ No 24a. Was an autopsy performed? page 2 Yes 2 No 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Anpatient 2 ER/Outpatient 3 DOA 2 2X No 28a. Date of injury (Month, Day, Year) funeral 27. Manner of Death 28b. Time of 28c. Injury at work? 1 Yes 2 No Certificate: 28d. Describe how injury occurred Natural 5 Pending injury within 24 hours after death.

To the Funeral Director, A completed filled in by the fu Investigation Accident 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 29a. Certifier 🔼 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) and title of cert 29d. Date signed (Month, Day, Year) 29b. Signature D51852

State Registrar 31. Date filed (Month, Day, Year)

NAR 3 1 2011

32 Registrar's Signature

7601

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DAVID A BRINKER, M.D.

OSLER DRIVE

3/24/2011

TOWSON, MD 21204

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. cedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 503 PM Medical Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death yrs. last birthday) Yrs. 8. Date of Birth (Month, Day, **Funeral** If Under 1 Year I If Under 24 Hrs. 9. Birthplace (State or Foreign 1 🗆 M 2 🖫 F 210 Hours Min. Country) < **Director** Usual Residence of Decedent items 23a or 28a-f show her must be notified at permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho any injury or other traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 12. Was Degedent Ever in U.S. Armed Forces?

1 Yes 2 No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married Completed by Maryland 21215-0036 1 Yes 2 No If Yes, Give Year or Dates Specify. 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ 19a. Informant's Name/Relationship (Type, 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Baltimore, Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date Burial 2 Cremation 3 Removal from State cemetery, crematory or other place) 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Liochses 22 Name and Address of Tus S Funeral Home, P. A. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. 23a, Part 1, Enter the disease. Approximate Interval Between Onset and Death Immediate Cause (Final Perforate Physician disease or condition Medical resulting in death) Examiner obstruc Sequentially list conditions, Examiner cause. Enter Underlying Cause (Disease or iinjury the Hospital or Attending Physician: The law requires that the death certificate be executed ate has been signed by the attending physician and page 2 should be detached for use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE yes, outcome of pregnancy
Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months?
1 Yes 2 No Year Pregnant at time of death 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Completed 2 🗌 No 3 🗆 Probably 4 🌠 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a, Was an autopsy performed? Yes 2 No After this certificate 1 🗌 Yes 2 🗌 No æ 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: 2 🗹 No Other: ျှ 1 Yes 1 Inpatient 2 PER/Outpatient 3 IDOA 4 Nursing Home 5 Residence 6 Other (Specify) Certificate: 27. Mann of Death 28a. Date of injury 28b. Time of 28c. Injury at 28d. Describe how injury occurred Natural (Month, Day, Year) 5 \square Pending work? 2 🗌 No Accident Investigation within 24 hours after death

To the Funeral Director:
completed filled in by the 3 Suicide 4 Homicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one 29b. Signature 29d. Date signed (Month, Day, Year) 00574 20// 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) DANIEL ark 1 way MD. 21218 31. Date filed (Month, Day, Year) State Registrar's 5 Registrar

11-02715

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene Samuel Amos 1- For State Certificate of Death Reg. No Registrar Time of Death 1. Decedent's Name (First, Middle,Last) 2. Date of Death Physician/ 0815 hrs April 9, 2011 Madical Examiner Samuel Amos 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (if not institution, give street and number) **Baltimore** Johns Hopkins Bayview Medical Center 8. Date of Birth (MM/DD/YYYY) 9. Birthplace (State or If Under 1 Year If Under 24Hrs. 7. Age (In yrs, last birthday) 5. Social Security Number **Funeral** Months Davs Hours Sept 18, 1930 Country)Maryland Director 80 219-22-9044 1 X M 2 F Yrs Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a State 10b County 1 Yes 2 X No Baltimore Baltimore or 28a-f show MD or items 23a or 28a-f sho must be notified at once. Pages 1 and 2 should be filed within 72 hours after death with the Maryland rent of Health and Mental Hygiene.

ant: If item 27 is marked other than "natural", or items 23a or 28a-f sho Director 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 21219 USA 2316 Lodge Farm Road 14. Race - American Indian, Black, uneral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-12. Was Decedent Ever in U.S. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) White, etc. Armed Forces? 1 Never Married 2 Married 2X No 1 Yes If Yes, Give Year or Dates: 1 Yes 2 X No specify: Specify: white 3 X Widowed 4 Divorced <u>≨</u> 16b. Kind of Business/Industry 16a, Decedent's Usual Occupation (Give kind of work done 15. Decedent's Education (Specify only highest grade completed) during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) event, the Medical Baltimore, MD 21215-0036 mechanic automotive 18.Mother's Name (First, Middle, Maiden Surname) 17, Father's Name (First, Middle, Last) Ada Lester Branham William Leonard Amos 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Sandra Amos/daughter 2316 Lodge Farm Road Baltimore, MD 20b. Place of Disposition (Name of cemetery, Date 20c. Location - City or Town, State 20a. Method of Disposition rtant: If it crematory or other place) 1 Burial 2 Cremation 3 Removal from State Department of Important: 4 X Donation 5 Other Specify 21. Sig ... re ... ineral Service Li ... nsec 22. Name and Address of Facility 2227 State Anatomy Board 655 W. Baltimore Street onald 8 Wade THE TIMORE, MD 21201

Teter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Approximate Interval **Physician** Between Onset and only one cause on each line. /Medical Death a. Hypertensive Atherosclerotic Cardiovascular Disease Immediate Cause IFI disease ≟xaminer or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, Due to (or as a consequence of): Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated Due to (or as a consequence of): events resulting in death) Last Hospital or Attending Physician: The law requires that the death certificate be executed Physician/Medical UNPENDED **AMENDED** signed by the attending physician be detached for use as the burial Box 68760. 23d. Date of delivery 23c. If yes, outcome of pregnancy IF FEMALE 23b. Was decedent pregnant in the 2 Fetal death 3 Ectopic pregnancy Month Day Year 1 Live birth past 12 months? Pregnant at time of death Other (Specify) 5 1 Yes 2 No 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, P.O. 1 Yes 2 No 3 Probably 4 Vunknown é End stage renal disease, diabetes mellitus Completed 24b. Were autopsy findings available this certificate has been a director, page 2 should 24a. Was an prior to completion of cause of this certificate has performed death? 1 🗸 Yes 2 No Yes 2 No 26.Place of Death (Check only one) 25. Was case referred to medical å examiner? Other Nursing Home 5 Residence 6 Other: 2 No ျှ 1 Yes After tl funeral 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death Certification: 1 V Natural 1 Yes 2 No 5 Pending Director: d in by the f within 24 hours after death. 2 Accident Investigation 28e. Place of Injury - At home, farm, street, factory, office building, etc 28f. Location (Street and Number or Rural Route Number, City 3 Suicide 6 Could not be or Town, State) (Specify) Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifie April 10, 2011 O.C.M.E. Musal 30. Name and address of person who completed cause of death (Item 23a) 111 Penn Street, Baltimore, MD 21201 Melissa Brassell, MD Assistant Medical Examiner 32. Registrar's Signature 31. Date filed (Month, Day, Year) State Registrar

ÖRIGINAL

DHMH 17 Rev 1/2001 OCME 2006

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death April 13, Physician/ 2011 5:30 PM Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Oueen Anne's Hospice Center Centreville 5. Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign 6. Sex 7. Age (In vrs. last birthday) **Funeral** Hours May 8, Day 1931 1 □ M 2 🟋 F Maryland 79 Director <u>217-30-8491</u> permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho any injury or other traumatic event, the Medical Examiner must be notified at. 10a. State 10b. County 10c. City, Town or Location 10d, Inside City Limits Director 1 Yes 2 X No MD Caroline Preston 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? Funeral 21182 Marsh Creek Road Lot E11 21655 USA 12. Was Decedent Ever in U.S. Armed Forces?
1 ☐ Yes 2 ☒ No
If Yes, Give 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. Completed by 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify: White 3X Widowed 4 ☐ Divorced Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Homemaker Own Home Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) (unk) Robert Walter Clough Frances 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 236 Three Creeks Drive Centreville, MD 21617 Jeanne Boyles-Fisher/daughter Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State cemetery, crematory or other place) 1 🔲 Burial 2 🔀 Cremation 3 🗆 Removal from State Final Journey Crematory 04/15/201 Woodbine, MD 4 Donation 5 Other (Specify) Signature of Funeral Service Lig Going Home Cremation Service P.O. Box 784 MD 21029 Heckrotte, P.A Clarksville. Reverly L. 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between 20 years Immediate Cause (Final Physician/ Chronic Obstructive Pulmonary Disease disease or condition) Medical resulting in death) Due to (or as a consequence of) Examiner Tobacco Use Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury Examiner Due to (or as a sur sequence of) Physician: The law requires that the death certificate be executed been signed by the attending physician and should be detached for use as the burial-transit that initiated events Due to (or as a consequence of) resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 3 Ectopic pregnancy
4 Pregnant at time of death 5 Other (specify) 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months?
1 Yes 2 No Day 1 ☐ Yes ∠-9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Diabetes, Lung Cancer, Hypertension 1 X Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available 24a. Was an prior to completion of cause of death? has performed? this certificate 1 ☐ Yes 2 ☐ No Yes 2 X No within 24 hours after death.

To the Funeral Director: After this certifics completed filled in by the funeral director, I 25. Was case referred to medical 26. Place of Death (Check only one) Certificate: To Be examiner? Hospital: 2.**X** No Other: 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Nother (Specify) Hospice 27, Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred or Attending 1X Natural 5 Pending 1 Tes 2 No Accident Sulcide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 🗌 Homicide determined Hospital Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Prectioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifie

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30. Name and address of person who completed compared Patricia A. Bowyer, M.D.

31. Date filed (Month, Day, Year)

APR 1 5 2011

DHMH 17 Rev 7/2009

Registrar

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32. Registrar's Signature

ror death (Item 23a) (Type, Print)
202 Coursevall Dr. Suite 101 Centreville, MD 21617

11-02777 Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Ernest Brown 1- For State Certificate of Death Reg. No. Registrar 2. Date of Death Decedent's Name (First, Middle,Last) Physician/ Month Day April 11, 2011 1658 hrs Ernest Brown Medical Examiner c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (if not institution, give street and number) **Baltimore County** Randallstown Northwest Hospital 8. Date of Birth (MM/DD/YYYY) 9. Birthplace (State or If Under 24Hrs. If Under 1 Year 5. Social Security Number 6 Sex 7. Age (In vrs. last birthday) **Funeral** Min Months Days Hours Country) MD Director 11-19-1967 216-98-8871 1 X M 2 F 43 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County 1 X Yes 2 No Baltimore MD n/a Director 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number USA 21215 3902 Annellen Road 14. Race - American Indian, Black, Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-11. Marital Status 12. Was Decedent Ever in U.S. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) White etc. Armed Forces' 1 Never Married 2 X Married Yes Ë African-American Yes 2 X No specify: 3 Widowed 4 Divorce ۾ 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation (Give kind of work done 15. Decedent's Education (Specify only highest grade completed) Completed during most of working life. DO NOT use retired) College (1-4 or 5+) Elementary/Secondary (0-12) Pages 1 and 2 should be filed within 72 1 ment of Health and Mental Hygiene. Fundamental Labors Baltimore, MD 21215-0036 Truck Driver Health and Mental Hygiene. I fiem 27 is marked other than rraumatic event, the Medic 12th 18.Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Fssie Jenkins Samuel B. Brown 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3902 Annellen Road, Raltimore, Md 21215 Roslyn T. McCaskill-Brown/Wife 20c Location - City or Town, State 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery crematory or other place) 1 Burial 2 Cremation 3 Removal from State 4-19-2011 Baltimore, MD Garden Of Faith 4 Donation 5 Other Specify Whie Funeral Home P.A. of Baltimore Co 22. Name and Address of Facility Ignature of Funeral Service Licenses 9200 Liberty Road, Randallstown, MD 21133 In I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respii atory arrest, shock, or heart Approximate Interval **Physician** Between Onset and failure. List only one cause on each line Death Wedical a. Acute Asthma Immediate Cause (Final disease aminer or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, Due to (or as a consequence of) if any, leading to immediate Examiner cause. Enter Underlying Cause (Disease or injury that initiated Due to (or as a consequence of) events resulting in death) Last led by the attending physician and detached for use as the burial - transit Physician/Medical AMENDED 23a, 27, per me, g917 7-25-11 sm X UNPENDED Hospital or Attending Physician: The law requires that the death certificate be Box 68760, 23d. Date of delivery 23c. If yes, outcome of pregnancy IF FFMALE: Year Month Day 23b. Was decedent pregnant in the 3 Ectopic pregnancy 1 Live birth Fetal death past 12 months? Pregnant at time of death 5 Other (Specify) 1 Yes 2 No 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, P.O. 1 Yes 2 No 3 Probably 4 Unknown ۾ Completed 24b. Were autopsy findings available 24a. Was an prior to completion of cause of autopsy performed' death? 1 🗹 Yes 2 No 1 ✓ Yes 2 No certificate 26.Place of Death (Check only one) 25 Was case referred to medical Be examiner? Other Nursing Home 5 Residence 6 Other: Hospital: 1 Inpatient 2 ✔ ER/Outpatient 3 DOA this 1 🗸 Yes 28c. Injury at Work? 28d. Describe how injury occurred 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury After 27. Manner of Death Certification: 1 X Natural 1 Yes 2 No Pending death. Director: Investigation 2 Accident 28f. Location (Street and Number or Rural Route Number, City 28e. Place of Injury - At home, farm, street, factory, office building, etc. 3 Could not be or Town, State) Suicide determined (Specify) Homicide

e Funeral Direc To the 1 within 2 To the 1

29a. Certifier 1

31. Date filed (Month,

29b. Signature and title of certifie

Theodore M. King, Jr., MD

and address of person who completed

15 2011

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State Registrar

and manner stated

Assistant Medical Examiner

32. Registrar's Signature

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29c. License number

O.C.M.E.

111 Penn Street, Baltimore, MD 21201

COME

29d. Date signed (Month, Day, Year)

April 12, 2011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 040nt 2-20 Pay Daniel Lee Baer 1454 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Upper Chesapeake Medical Center Bel Air Harford If Under 1 Year If Under 24 Hrs. 5. Social Security Number 7. Age (In vrs. last birthday) 8. Date of Birth Birthplace (State or Foreign Country) **Funeral** Days Min. Months Hours 1**X** M 2 □ F 1 2 - 13 - 1953 MD 217-64-0969 57 **Director** Usual Besidence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at Director 10c. City, Town or Location 10d. Inside City Limits 10a. State Harford Forest Hill 1 Yes 2 No 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? Funeral 1623 Louanne Ct #C 21050 USA Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S 14. Race - American Indian, 11 Marital Status Armed Forces?

1 Yes 2 No Black, White, etc. δ 1 Never Married 2 X Married Maryland 21215-0036 1 ☐ Yes 2 X No Specify. If Yes, Give Specify: White Completed 3 Widowed 4 Divorced Year or Dates Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Carpenter Home Improvement Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) ဨ Carl Baer Elva Reno 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Cathy Nolan-Baer (Wife) 1623 Louanne Ct #C Forest Hill, MD 21050 Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 X Cremation 3 Removal from State Atlantic Crematory 04-14-2011 Glen Burnie, MD 4 Donation 5 Other (Specify) 22. Name and Address of Facility 21. Signature of Funda 15 of ce License Schimunek Funeral Home of BelAir MacPhail Rd BelAir, MD 21014 610 W. 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final Physician/ IVER months Medical resulting in death) Due to (or as a consequence of): Examiner HEDATO K Sequentially list conditions, if any, reading to increase cause. Enter Underlying Cause (Disease or iinjury Examiner Our to lor as a consequence of this certificate has been signed by the attending physician and ral director, page 2 should be detached for use as the burial-transit executed that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Hospital or Attending Physician: The law requires that the death certificate be 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death
4 Pregnant at time of death
9 Unknown 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy
5 Other (specify) in the past 12 months?
1 Yes 2 No Month 1 Yes 2 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Abusie 2 No 3 Probably 4 Unknown Records, Be Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy perform 1 Yes 2 No Yes Vital 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No ျ 1 Yes 1 Inpatient 2 ER/Outpatient 3 DOA Division of funeral Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work?
1 ☐ Yes 2 ☐ No Certificate: 28d. Describe how injury occurred nin 24 hours after death. the Funeral Director: After injury 5 Pending Natural Accident
Suicide Investigation completed filled in by the 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) within To the 29b. Signature and title of ce 29d, Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print OP 104 CHESAPEAKE 21015

DHMH 17 Rev 7/2009

State Registrar 31. Date filed (Month, Day,

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32. Registrar's Signatur

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Physician/ 0540 Bushman Medical retoria 4a. Facility Name (if not institution, give street and number, 4b. City, Town, or Location of Death 4c. County of Death Examiner Randallstown Season's Hospice at Northwest Hospital Center Baltimore . Age (In yrs. last birthday) 9. Birthplace (State or Foreign 6. Sex If Under 1 Year If Under 24 Hrs. 8. Date of Birth 5. Social Security Number 216-42-9569 **Funeral** 1 🗆 M 2 🛣 F Months Days Hours JUN 3. 1944 Kentucky Director 66 Usual Residence of Decedent or than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at 10a. State 10b. County 10d. Inside City Limits 10c. City, Town or Location Director 1 🗌 Yes 2 🙀 No Maryland Carrol1 Sykesville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 7614 Patapsco Drive 21784 USA within 72 hours after death 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian 11. Marital Status Armed Forces?

1 Yes 2 No
Wes Give X 1 Never Married 2 Married þ Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 X No Specify: Specify: White 3 X Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business Industry and Mental Hygiene. is marked other than Elementary/Seconday (0-12) College (1-4 or 5+) Emergency Room Care Registered Nurse Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ၉ Rov Greer Vida Walker pe permit. Page 1 and 2 should be Department of Health and Ment Important: If item 27 is marke any injury or other traumatic once. traumatic 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Toni Pennington/daughter 312 Greenwood Circle Panama City Beach, FL 32407 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other place, 1 Durial 2 X Cremation 3 Removal from State All County Cremation Service 4/16/2011 | Sykesville, Maryland 4 ☐ Donation 5 ☐ Other (Specify) Haight Funeral Home & Chapel, P.O. Box 195 Sykesville, MD 21 21. Signature of Funeral Service License max (410-795-1400)23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Pnysician/ Breest Can disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner mus Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of) attending physician and for use as the burial-transit Cause (Disease or linjury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Hospital or Attending Physician; The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant Ectopic pregnancy in the past 12 months?
1 Yes 2 No Month Pregnant at time of death 5 Other (specify) signed by the at d be detached for Linknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 2 No 3 Probably 4 Unknown anstructur been si Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an neral Director: After this certificate has filled in by the funeral director, page 2 autopsy performed? ''00 2 No 2 No 1 🗌 Yes 1 Yes 2 Be 25. Was case referred to medical 26. Place of Death (Check only one) Season's examiner?
1 Yes 2 No Hospital Other: 4 Nursing Home 5 Residence 6 Other (Specify) ဂ္ 1 Inpatient 2 ER/Outpatient 3 IDOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred 24 hours after death. Funeral Director: After work?
1 Yes 2 No 1 Natural injury 5 Pending 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier within 24 ho

To the Fune

completed fi Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. the only one) 29b. Signature and title of certifie 29d. Date signed (Month, Day, Year) 2 02908 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 101 21133 T CHIA CCURT

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State Registrar 31. Date filed (Month, Day, Year) APR 1 5 2011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene for State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death 10:55P 2011 Physician/ April 12, HELEN BALDASSARI Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Baltimore Towson Gilchrist Social Security Number Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign 6. Sex **Funeral** 1 □ M 2**X**XF 88 Months Days Hours Min. 191-14-4401 03/10191923 Pemisÿlvania Director Usual Residence of Decedent 28a-f show 10b. County 10d. Inside City Limits er than "natural", or items 23a or 28a-f sho the Medical Examiner must be notified at 10a. State 10c. City. Town or Location Director 1 Yes 2XX No Maryland Baltimore Cockeysville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21030 USA 22 Snowberry Court · death \ 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14 Race - American Indian. 11. Marital Status Armed Forces 1 If Yes, specify Cuban, Mexican, Puerto Rican, etc. Black, White, etc. 1 Never Married 2 Married þ Maryland 21215-0036 be filed within 72 hours after 1 Yes XX No Specify: If Yes, Give Year or Dates 3 XWidowed 4 □ Divorced Completed White Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business Industry al Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) Own Home Homemaker traumatic event, Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) and Mental f permit. Page 1 and 2 should be Department of Health and Ment. Important: If item 27 is marked any injury or Add. ည Peter Hostinar Mary Dudash 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 22 Snowberry Court Cockeysville, Maryland 21030 Audrey A Iltis Daughter Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place, 20c. Location - City or Town, State U□ Burial 2XX Cremation 3 □ Removal from State GreenMount Crematory 04/13/2011 Baltimore, Maryland ☐ Donation 5 ☐ Other (Specify) ignature of Funeral Se 22. Name and Address of FaMirtchell-Wiedefeld Funeral Home Inc 6500 York Road Baltimore, Maryland 21212 23a. Part 1. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Pnysician/ disease or condition Medical resulting in death) Due to (or as a consequence of **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of) attending physician and for use as the burial-transit Cause (Disease or linjury that initiated events resulting in death) Last Due to (or as a consequence of): Be Completed by Physician/Medical e Hospital or Attending Physician. The law requires that the death certificate be 24 hours after death.

24 hours after death.

5 Funeral Director. After this certificate has been signed by the attending physicia is Funeral director, page 2 should be detached for use as the bunneled filled in by the tuneral director, page 2 should be detached for use as the bunneled. Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 r 1 Yes 2 9 Unknown months? Month Day Other (specify) Pregnant at time of death contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 🗌 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an autopsy 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital: Other: 2 No ဂ္ 1 Tes 1 Inpatient 2 ER/Outpatient 3 DOA Pice 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) Manner of Death 28b. Time of 28c. Injury at work? 1 ☐ Yes 2 ☐ No Certificate: 28d. Describe how injury occurred iniury 1X Natural 5 Pending Accident Investigation 6 Could not be 3 Suicide
4 Homicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) Medical 💢 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifie completed Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Sertifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. within 2 To the F one) 29b. Signature 29d. Date signed (Month, Day, Year) T8111000 (3 ss of person who completed cause of death (Item 23a) (Type, Print) Suite 4/05, Balthare, MO, 21204

DHMH 17 Rev 7/2009

State Registrar

0 32. Registrar's

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death Reg. No. 2. Date of Death . Decedent's Name (First, Middle, Last) Time of Death Yea Physician/ April 11, 2011 7:15P Evelyn Beck Butterhoff Medical 4c. County of Death 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** None Baltimore Hamilton Center 9. Birthplace (State or Foreign Social Security Numbe 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. 8. Date of Birth Sex 1 M 2 XX **Funeral** Months Days Hours 06/06/1924 Maryland Director 86 216-18-9237 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State filed within 72 hours after death with the Maryland an "natural", or items 23a or 28a-f sho Medical Examiner must be notified at Director 1XX Yes 2 □ No Baltimore Maryland None 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number Funeral 21214 USA 6040 Harford Road Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. 11. Marital Status Armed Forces?
1 ☐ Yes 2XX No Black, White, etc. þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 🏋 No If Yes. Give Specify White Completed 3XXWidowed 4 ☐ Divorced Year or Dates. 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business Industry Elementary/Seconday (0-12) College (1-4 or 5+) the Pianist 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) permit. Page 1 and 2 should be file Department of Health and Mental i Important: If item 27 is marked o any injury or other traumatic evence. ည Agnes Smrha John Charles Beck 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3029 California Avenue Baltimore, Maryland 21234 Dtr Mary Ambrose 20c. Location - City or Town, State Method of Disposition 20b. Place of Disposition (Name of Date ឺ Burial 2 🗆 Cremation 3 🗖 Removal from State Garrison Forest Veterns Cen 04/18/2011 Owings Mills, Maryland ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Mitchell-Wiedefeld Funeral ignature of Funer 6500 York Road Baltimore, Maryland 21212 23a, Part 1. Enter the disease, or co shock, or heart failure. List or nplications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, one cause on each line. Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of): **Examiner** Sequentially list conditions, Examine it any, leading to immediate cause. Enter Underlying Cause (Disease or linjury 10 thrive the Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-trans that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregna 5 Other (specify) Ectopic pregnancy in the past 12 months? Month Day Pregnant at time of death Yes 2 No the 1 L Yes 2 L g Unknown s been signed by the should be detached Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ş 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Onknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an sate has page 2 s autopsy performed Yes 2 2 14 No 1 Yes this certificate funeral director, 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: 2 1 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1 🗌 Yes 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) မ Date of injury (Month, Day, Year) 28b. Time of 27. Manner of Death 28c. Injury at 28d. Describe how injury occurred Certificate: 1 Natural 5 Pending work? 1 🗌 Yes 2 🗌 No 2 Accident
3 Suicide
4 Homicide Investigation within 24 hours after death

To the Funeral Director; /
completed filled in by the f 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature ar title of certifier 100 25 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 31. Date filed (Month, Day, Year) State 5 Registrar

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registra Certificate of Death Reg. No 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Year Melvina Brown 08 30 PM APRI 06 201 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** AGNES HOSPITAL SAINT Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Jun 1, 1936 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) **Funeral** Days 1 M 2 X F Months Hours So. Carolina Yrs. Director 74 216-30-6152 Usual Residence of Decedent 28a-f shov 10b. County ir than "natural", or items 23a or 28a-f sho the Medical Examiner must be notified at 10a. State 10c. City, Town or Location 10d. Inside City Limits within 72 hours after death with the Maryland Director 1 ☐ Yes 2 ☐ No **Baltimore** Maryland Baltimore 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? Funeral 21207 U.S.A. 1101 Sanbourne Road 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. ģ 1 Never Married 2 KMarried ☐ Yes 2 🕱 No Yes, Give Baltimore, Maryland 21215-0036 1 Yes 2 KNo Specify Black Specify: 3 Widowed 4 Divorced Completed Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) and Mental Hygiene. Elementary/Seconday (0-12) Alfend Packing College (1-4 or 5+) Inspector 12 traumatic event, Be filed permit. Page 1 and 2 should be filed. Department of Health and Mental Infortant: If item 27 is reany injury or other 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Frank Clark Pearl Clark 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1101 Sanbourne Road Baltimore, Maryland 21207 Harry Brown 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 □XBurial 2 □ Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify) Windsor Mill, Md. 04/13/11 King Memorial Park of Funeral Service 22. Name and Address of Facility Estep Brothers Funeral Service, P 1300 Futaw Place Baltimore, Md 21217 art 1. Enter the disease, or complications that caused hock or heart failure. List only one cause on each line he death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Immediate Cause (Final Onset and Death Physician/ Pheumonio disease or condition Medical resulting in death) Due to (or as a consequence of) **Examiner** Pt Sequentially list conditions, Examiner Due to (or as a consequence of): if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury The law requires that the death certificate be executed attending physician and for use as the burial-transit Rena that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical JECKYS EMPHYSEINA Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregna 5 Other (specify) Ectopic pregnancy in the past 12 months?
1 Yes 2 No Month Day Year Pregnant at time of death signed by the Unknown 9 Unknown 00 Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? à 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🗷 Unknown Division of Vital Records, Completed page 2 should 24b. Were autopsy findings available prior to completion of cause of 24a. Was an has autopsy performed? death? After this certificate 2 🗆 No 2 🗷 No 1 Tes Yes Physician: 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 2 X No 1 TYes မြ 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) eral Director: After this filled in by the funeral 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred To the Hospital or Attending Natural 5 Pending Accident 1 Tes 2 🗌 No Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 - Homicide determined City or Town, State) within 24 hours a Medical Exertifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a, Certifier (Check 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifi MD. 0069177 2011 APRIL 06 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) MD. 21229 AVE. BAITIMORE VALIKHANI CATON 900 MOHAMMAD

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Registrar

31. Date filed (Month, Day, Year)

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32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death April Physician/ 58 AM Barth 201 0 Medical 4a. Facility Name (if not Institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** University of Maryland Medical Baltimor If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign 6. Sex 8. Date of Birth 5. Social Security Number 7. Age (In vrs. last birthday) **Funeral** Days June 29 Year 1929 Maryland Months Hours Min. 1 □ M 2 🔀 F 220-22-8647 81 Director Usual Residence of Decedent 10d. Inside City Limits or 28a-f shov 10a. State 10b. County 10c. City, Town or Location ir than "natural", or items 23a or 28a-f sho the Medical Examiner must be notified at filed within 72 hours after death with the Maryland Director 1 ☐ Yes 2x No Baltimore Baltimore MD 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral USA 21234 8800 Walther Blvd #2014 Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, 11, Marital Status Armed Forces Black, White, etc. Yes 2 XNo 1 Never Married 2 X Married þ Baltimore, Maryland 21215-0036 white 1 ☐ Yes 2 X No Specify: If Yes, Give 3 Divorced 4 Divorced Completed Year or Dates. 16a. Decedent's Usual Occupation 16b. Kind of Business Industry 15 Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life, DO NOT use retired) al Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) telephone company 12 0 clerk permit. Page 1 and 2 should be filed Department of Health and Mental Hy, Important: If item 27 is marked othe any injury or other traumait. Be other traumatic event, 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) ဂ္ Sophia Tieble Russell Wilson Filbert 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 8800 Walther Blvd #2014 Baltimore, MD 21234 Edward H. Bartholomay/spouse 20b. Place of Disposition (Name of 20c. Location - City or Town, State 20a. Method of Disposition cemetery, crematory or other place) ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 X Donation 5 ☐ Other (Specify) State Anatomy Board 655 W. Baltimore Street 21. Signa ure Luneral Servi Baltimore, MD 21201 Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or beart failure. List only one cause on each line. Approximate Interval Retween Onset and Death Immediate Cause (Final emi Physician/ disease or condition resulting in death) Medical a consequence of): Due to (or **Examiner** Sequentially list conditions Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of): To the Hospital or Attending Physician: The law requires that the death certificate be executed use as the burial-transit and that initiated events Due to (or as a consequence of) resulting in death) Last attending physician Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy
5 Other (specify) ____ Year in the past 12 months?
1 ☐ Yes 2 ☑ No Month Dav detached for Pregnant at time of death Yes 9 Unknown the Unknown þ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? s been signed the should be detailed by 2 No 3 Probably 4 Unknown 1 Yes Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 s autopsy has performed' 1 ☐ Yes 2 ☐ No Yes 2 L within 24 hours after death.

To the Funeral Director: After this certific completed filled in by the funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 2 🗹 No မ 1 🗌 Yes 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28b. Time of 27. Manner of Death 28a. Date of injury 28c. Injury at 28d. Describe how injury occurred Certificate: (Month, Day, Year) injury work' 1 Natural 5 Pending 1 Tes 2 🗌 No Accident
Suicide Investigation 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. The basis of examination and a strength of the basis of examination and a strength of the cause (s) and manner as stated at the time, date and place, and due to the cause (s) and manner as stated only one) 29b. Signature and title of certifier 112011 M.D. n 1st yn anthe Press of person who completed cause of death (Item 23a) (Type, Print)

Tha Smrth 22 5 Greene St. Baltmore, MD samantha Omith 31. Date filed (MP) 32. Registrar's Signature State

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death Reg. No/ 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Year Month O 4 Physician/ 14:28 M Blackburn 201 Larry Wayne . Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Union Memorial Hospital Baltimore If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign Social Security Number 6. Sex 1 X M 2 □ F 7. Age (In yrs. last birthday) **Funeral** Davs Hours 9/1/1939 North Carolina Director 213-36-<u>2524</u> 71 Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items on other trainments. 10d Inside City Limits 10a. State 10b. County 10c. City, Town or Location Director 1 Tes 2 X No Baltimore Rosedale Maryland 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21237 S. 5365 King Arthur Circle 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, 11. Marital Status Black White etc. 1 V Yes 2 No 1954 If Yes, Give Completed by 1 Never Married 2 Married ☐ Yes 2 Mo Specify: Specify. 3 XWidowed 4 □ Divorced 1964 White Year or Dates 16a. Decedent's Usual Occupation 15. Decedent's Education 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) 11 Production Worker Auto Manufacturing Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ဂ္ Marion Levy Blackburn Hester Frances 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3820 Federal Lane Abingdon, Kelly A. Getz (Daughter) MD 21009 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 XBurial 2 Cremation 3 Removal from State 2615 Holly Hill Mem. Gard. 4 ☐ Donation 5 ☐ Other (Specify) Middle River, MD 22. Name and Address of Facility Bruzdzinski Funeral Home 1407 Old Eastern Avenue Signature of Funeral Service Licenses Maryland 21221 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate shock, or heart failure. List only one cause on each line Interval Between Onset and Death Immediate Cause (Final Physician/ Respiratory disease or condition resulting in death) minutes Medical Due to r as a consequence of: 3 months Examiner sophagenl Cance Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury Examine Day to forms reconstructions of OPD To the Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-trans that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Month Year 5 Other (specify) Pregnant at time of death Unknown signed by the Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. by 1 Ves 2 No 3 Probably 4 Unknown Completed peen a 24b. Were autopsy findings available prior to completion of cause of 24a. Was an within 24 hours after death.

To the Funeral Director. After this certificate has to the Funeral Director. After this certificate has to the funeral director, page 2 s autopsy death?
1 Yes 2 No performed? Yes 2 No 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Hospital 은 1 🗌 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 28c. Injury at work?
1 ☐ Yes 2 ☐ No Certificate: Manner of Death 28b. Time of 28d. Describe how injury occurred injury 1 E Natural 5 Pending 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check 3 only one) 29b. Signature and title of 29d. Date signed (Month, Day, Year) 29c. License number

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30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

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31. Date filed (Month, Day, Year)

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.
AMEND ITEM# 20b, perFH, G914, 4/20/2011, WS
State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month **BRUNSON** 7:200 Ann Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death Examiner 4b. City, Town, or Location of Death BALTIMORE RANDALLSTOWN SEASONS HOSPICE 5. Social Security Number If Under 1 Year | If Under 24 Hrs. . Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Days Months (Month, Day, Year) 11-24-1929 1 M 2 TF Hours Director 247-60-1668 SC Usual Residence of Decedent 28a-f shov 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 Ves 2 No MD 10e. Street and Number 10f. Zip Code ō 10g. Citizen of What Country? pe Funeral 5500 LEXINGTON RD. 21207 USA Page 1 and 2 should be filed within 72 hours after death 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian, Examiner Armed Forces?

1 Yes 2 No
If Yes, Give
Year or Dates. Black, White, etc. ò þ 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 😾 No Specify. "natural", 3 XWidowed 4 ☐ Divorced Specify Completed BLACK the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) I Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) DOMESTIC HOUSEWORK Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) th and Mental H

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traumatic ever မ JAMES STUCKEY LUCILLE MCDANIEL 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) tem 27 of Health REV. RUBY PURNELL 1716 N. SMALLWOOD ST. BALTIMORE, MD 21216 Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ▼ Burial 2 □ Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify) 4/18/1 ± 5 Department of Important: If any injury or once, CEDAR HILL CEMETERY 4-25-2011 BALTIMORE, MARYLAND 21. Signature of Funeral Service Licenses 22. Name and Address of Facility JAMES A. MORTON & SONS F.H., INC. ames a. 1701-31 LAURENS ST. BALTIMORE, MD 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line. Immediate Cause (Final Physician/ disease or condition resulting in death) Due to (or as a consequence of): Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Physician/Medical Examiner Due to (or as a consequence of): within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit Cause (Disease of liftjury Callul-1-5 that initiated events resulting in death) Last Due to (or as a consequence of): Box 68760 yes, outcome of pregnancy

Live Birth 2 Fetal death
Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
 5 Other (specify) in the past 12 months?

1 Yes 2 No Month Day Year P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ò Division of Vital Records, Completed MULAL to bean 1 🗌 Yes 2 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of Sunnamy 24a. Was an 3hc-+ autopsy perform death? Yes 2 No 2 No 1 Yes 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Other: 4 Nursing Home 5 Residence မ ER/Outpatient 3 DOA 1 Inpatient 2 I Certificate: 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred To the Hospital or Attending 1 Natural 5 Pending injury work? 1 \sum Yes 2 \sum No Accident Investigation Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined Medical 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 L 3 L 29b. Signature and title of certifier 29d, Date signed (Month, Day, Year) 1le 122085 2011 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 21133 MA OLA COURT 31. Date filed (Month,-Day, Year) 32. Registrar's Signature State Registrar

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Eric William Brown .2011 9:50P Apri Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Genesis Health Care, Perring Parkway Baltimore Social Security Number 6. Sex 9. Birthplace (State or Foreign Country) Mary Land **Funeral** 7. Age (In vrs. last birthday) If Under 1 Year | If Under 24 Hrs. 8. Date of Birth 1 🕅 M 2 🗆 F Months Hours 213-13-7350 Nov. 15, 1974 **Director** 36 Usual Residence of Decedent 28a-f show 10a. State 10h Counts within 72 hours after death with the Maryland 10c. City, Town or Location 10d. Inside City Limits must be notified at Director Maryland Baltimore Parkville 1 Yes X No o 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? Funeral 23a 1 Lava Court, Apt.1D 21234 U.S.A. permit. Page 1 and 2 should be filed within 72 hours after death v Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items any injury or other traumatic event, the Medical Examiner mu 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces? Black, White, etc. 1 X Never Married 2 Married þ Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🕅 No Specify. 3 Widowed 4 Divorced If Yes. Give Specify: Black Completed Year or Dates. 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Cab Driver 4 Transpotation Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 Herbert E. Brown Jacquoline Smith 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Stephanie Jerger 1 Lava Court, Apt1D, Parkville, Maryland 21234 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) ArdentCremation, Inc. 4-13-11 Hanover, Maryland 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Marzullo Funeral Chapel,P.A. d, Baltimore,Maryland 21214 michae 6009 Harford Road, 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Aspination Onset and Death Physician disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner Sequentially list conditions if any, leading to immediate cause. Enter Underlying Exami Hospital or Attending Physician: The law requires that the death certificate be executed Munia Cause (Disease or linjury attending physician and for use as the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Month Year Day Pregnant at time of death 5 Other (specify) the Unknown þ signed t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ĝ Completed 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 X Unknown Were autopsy findings available prior to completion of cause of death? 24a, Was an has page 2 autopsy performed? 1 Yes 2 K No After this certificate 1 ☐ Yes 2 No Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital 2 🕅 No Other: <u>م</u>| 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 Natural 2 Accident 3 Suicide 5 Pending injury work? 1 ☐ Yes 2 ☐ No within 24 hours after death.

To the Funeral Director: A completed filled in by the fu Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined Medical 29a. Certifier 1 🗓 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 29b. Signature and title of certifier Atysizian wo 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) N-GUTAN ST. State 2011 Registrar

H DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar 191 Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Chiu Hungdah April 12 Physician/ 5:30 2011 A^{M} Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death **Examiner** Howard Columbia Sunrise Assisted Living 8. Date of Birth (Month, Day, Yea Mar 23, g. Birthplace (State or Foreign If Under 1 Year If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday **Funeral** Hours 1 X M 2 □ F China 1936 **Director** 029-34-2892 Usual Residence of Decedent 10d. Inside City Limits 28a-f shov 10b. County 10c. City, Town or Location within 72 hours after death with the Maryland er than "natural", or items 23a or 28a-f sho the Medical Examiner must be notified at 10a, State **Funeral Director** 1 ☐ Yes 2 🛣 No Columbia Howard 10f. Zip Code 10g. Citizen of What Country? 10e Street and Number Republic of China 21044 6168 Devon Drive 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. 11. Marital Status Armed Forces?

1 Yes 2 No Black, White, etc. 1 Never Married 2 Married þ Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify: If Yes, Give Year or Dates Specify: Chinese 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry permit. Page 1 and 2 should be filed within 72 h
Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "ni
any injury or other traumatic event, the Media
once. College (1-4 or 5+) 5+ Elementary/Seconday (0-12) Law Professor University Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) မ Ming-Non Young Han-Ping 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 6168 Devon Drive Columbia, MD 21044 19a. Informant's Name/Relationship (Type, Print) Yuan-Yuah Chiu/wife 20c. Location - City or Town, State 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) ☐ Burial 2 X Cremation 3 ☐ Removal from State Final Journey Crematory 04/14/11 Woodbine, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Sign ure of Funeral Service Lice Going nome Cremation Service P.O. Box 784 Beverly L. Heckrotte, P.A. Clarksville, MD 21029 MO1251 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death
13 years a Cerebral Infarction Immediate Cause (Final Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions Examine Due to (or as a consequence of) if any, leading to immediate cause. Enter Underlyin Cause (Disease or linjury the attending physician and thed for use as the burial-transit Physician: The law requires that the death certificate be executed that initiated events Due to (or as a consequence of) resulting in death) Last Physician/Medical Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregna 5 Other (specify) Live Birth 2 L retail use.
Pregnant at time of death Ectopic pregnancy in the past 12 months? Month Year signed by the a ld be detached for 2 No 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by Vascular Dementia, Atherosclerosis 2 No 3 Probably 4 Unknown 1 Yes 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy performed? Yes 2 No has e 2 certificate ha death? 1 Yes 2 No 26. Place of Death (Check only one) Division of Vital Be 25. Was case referred to medica assisted Living Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 🔀 No 1 Inpatient 2 ER/Outpatient 3 DOA ၉ this 27. Manner of Death 28b. Time of 28a. Date of injury (Month, Day, Year) 28d. Describe how injury occurred To the Hospital or Attending Pt within 24 hours after death.

To the Funeral Director: After th completed filled in by the funeral 28c. Injury at Certificate: 1 X Natural 5 Pending 1 Yes 2 No 2 Accident
3 Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Medical Xcertifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: To the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check 3 🗌 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License numbe mD. D56531 April 13, 2011 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 00. Harry Li, M.D. 8600 Snowden River Pkwy. #301 Columbia, MD 21044 32. Registrar's Signature 31. Date filed (Month, Day, Year) State APR 15 2011

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene for State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death . ^{Day} 20<u>11</u> April Physician/ 8:18 A M 12 Calabrese Angelo Michael Medical 4c. County of Death 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner Baltimore Towson Gilchrist Hospice | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth | Months | Days | Hours | Min. | Month | Apr 28, | 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) 5. Social Security Number **Funeral** 1**X**□ M 2 □ F Massachusetts 1919 Director 011-16-5088 Usual Residence of Decedent ms 23a or 28a-f show must be notified at 10d. Inside City Limits 10b. County 10c. City, Town or Location 10a. State within 72 hours after death with the Maryland Director 1 ☐ Yes 2 No Columbia MD Howard 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number USA Funeral 21044 6336 Cedar Lane #371 items Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. 11. Marital Status J Hygiene. other than "natural", or iten vent, the Medical Examiner! Armed Forces? Black, White, etc. 1 Never Married 2 Married þ Maryland 21215-0036 1 Yes 2 XNo Specify: Specify: White If Yes, Give Year or Dates. 1939-43 3 Divorced 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business Industry Elementary/Seconday (0-12) College (1-4 or 5+) US Postal Service Postal Worker Ith and Mental Hygie 27 is marked other r traumatic event, the Ве 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) ည Josephine Bastile Charles Calabrese permit. Page 1 and 2 should be Department of Health and Ment Important: If item 27 is marke any injury or other traumatic once. 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 7299 Meadow Wood Way Clarksville, MD 21029 Joanne Serelis/daughter Saltimore, 20c. Location - City or Town, State 20b. Place of Disposition (Name of 20a. Method of Disposition cemetery, crematory or other place) 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Final Journey Crematory 04/13/2011 Woodbine, MD Coing Home CRemation Service P.O. Box 784 21029 Beverly L. Heckrotte, P.A. Clarksville, MDMO1251 Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ Juno1 NENOWA disease or condition Medical resulting in death) (or as a consequence of) **Examiner** Se juentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events resulting in death) Last Due to (or as a consequence or): Examine attending physician and for use as the burial-transit Due to (or as a consequence of): Physician/Medical or Attending Physician: The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 IF FEMALE: yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 3 D Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Month Year Day 5 Other (specify) Pregnant at time of death sate has been signed by the page 2 should be detached 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by 2 000 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 ☐ Yes 2 ☐ No certificate the funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital 2 No မ 1 Yes 1 Inpatient 2 ER/Outpatient 3 DOA within 24 hours after death.

To the Funeral Director: After this 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury at Certificate: work? 1 Natural iniury 5 Pending 2 🗆 No Accident Investigation 6 Could not be Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) completed filled in by 4 Homicide determined To the Hospital Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one 29b. Signature and title of certifie who completed cause of death (Item 23a) (Type, Print) 30. Name and add WO 31. Date filed (Month, Day, State APR 1 5 2011 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.
nend #26 Per PHY G914 4/15/2011 JH
State of Maryland / Department of Health and Mental Hygiene amend #29d Per PHY G914-4-119-2011 Death Reg. No. 2. Date of Death 3. Time of Death . Decedent's Name (First, Middle, Last) Month Day Year 5:38 рам **Physician** 04 11 2011 COUPLIN /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner BALTIMORE ESSEX 1626 HOPEWELL AVE. Birthplace (State or Foreign Country) If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 5. Social Security Number 7. Age (In vrs. last birthday) **Funeral** 1 □XM 2 □ F Months Days Hours Yrs. 78 MD 01-13-1933 Director 212-30-4981 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County ral', or items 23a or 28a-f ehow Exeminer must be notified at 1 ☐ Yes 2 🛣 No Director MDBALTIMORE ESSEX 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number U.S.A. 21221 1626 HOPEWELL filed within 72 hours after death Funera 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 2 No if Yes, Give Year or Dates: Race - American Indian, Black, White, etc. 11. Marital Status 1 Never Married Married Baltimore, Maryland 21215-0036 1 ☐ Yes 🌠 No Specify: Specify: þ BLACK 3 ☐ Widowed 4 ☐ Divorced "natural" Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) STEEL INDUSTRY STEEL WORKER 11th 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be is marked of Pages 1 and 2 should be ADA COUPLIN 2 BENJAMIN COUPLIN 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Health i 1626 HOPEWELL AVE. BATIMORE, MD 21221 PATRICIA COUPLIN/WIFE Item 2 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition p I ö 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State permit. Page Department of Important: If any injury or once. HOLLY HILL MEM. GARD. 04-16-2011 BALTIMORE, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service 22 Name and Address of Eaching WILLIAM C. BROWN COMMUNITY FUNERAL HOME PA. BATTIMORE, MD 21217 1206 W. NORTH AVE. Nun Approximate Interval Between Onset and Death Add1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Inmediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any leading II immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of): Examiner The law requires that the death certificate be executed signed by the attending physicien and d be detached for use as the burial-transit resulting in death) Last Due to (or as a consequence of) Records, P.O. Box 68760, ysiclan/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Day Year in the past 12 months? 5 Other (specify) 4☐Pregnant at time of death 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ð 2 No 3 Probably 4 Unknown cum on 10 Completed has been 24b. Were autopsy lindings available prior to completion of cause of death? 24a. Was an autopsy 1 ☐ Yes 2 ☐ No certificate 2ZINo **Division of Vital** the Hospital or Attending Physician: After this certification funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Hospital: 1 ☐ Inpatient Other_ 1 ☐ Yes 2 No 2 ER/Outpatient 3□ DOA Tring Home 5 X esidence 6 Other (Specify) 28c. Injury at Work? 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred 27. Manner ol Death 28b. Time of Certification: Natural 5 Pending 2 No death. 1 Tes 2 Accident investigation Director: filled in by the 28l. Location (Street and Number or Rural Route Number, City or Town, State) 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, lactory, office building, etc. (Specify) within 24 hours after To the Funeral Direct 4 Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) ca (Check only one) and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 4/14/2011 Pulcian Pulce-1MV Ba Ho, MD 21237 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Philadelphia Road 9110 Inclain fuilne 31. Date filed (Month, Day, Year) Registrar's Signature State 5 2011 Registrar

DHMH 17 Rev 1/2001

ORIGINAL

11-02759 Callaway

1- For State
Registrar

Physician/

1. Decedents

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	1- For State Certificate of Death Reg. No.
Physician/ ledical Examiner	1. Decedent's Name (First, Middle,Last) 2. Date of Death Month Day Year O151 hm
	4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 1700 Block of Crystal Avenue 4c. County of Death Baltimore
Funeral Director	5. Social Security Number 2 1 6 - 3 5 - 1 0 6 7 (Sex 1/2 In yrs. last birthday) 19 Birthplace (State or Months Days Hours Min. 0 2 / 27 / 1 9 9 2 Foreign MD Country)
iow any	Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits MD Baltimore 1x Yes 2 No
the Maryland o or 28a-f show iffed at once. Director	10e. Street and Number 325 McMechen Street Apt. 200 21217 USA
or items 23, must be not Funeral	11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 15. Was Decedent Ever in U.S. 16. Yes, specify Cuban, Mexican, Puerto Rican, etc.) 16. Race - American Indian, Black, White, etc. 17. Yes 2 X No specify: 18. Race - American Indian, Black, White, etc. 19. Performance of the property of
5-0036 led within 72 hours after the within 72 hours after the "natural", the Medical Examiner Completed by	15. Decedent's Education (Specific collections) 16a Decedent's Lisual Occupation (Give kind of work done 16b. Kind of Business/Industry
21215-0036 Juid be filed within 72 hour I Mental Hygiene. In marked other than "matu ic event, the Medical Exat To Be Completed	12 Salesperson Retail 17. Father's Name (First, Middle, Last) unk Constance Callaway
MD 21215-0 d 2 should be filed w lth and Mental Hygic n 27 is marked othe numatic event, the N To Be Co	19a. Informant's Name/Relationship (Type, Print) Constance Callaway 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 325 McMeden Street Apt. 201Balt.MD 21217
Baltimore, MD 2121 pernit. Pages 1 and 2 should be fi Department of Health and Mental 1 Important: If item 27 is marked injury or other fraumatic event, TO Be	20a, Method of Disposition 1 X Burial 2 Cremation 3 Removal from State 4 Donation 5 Other Specify: 20b. Place of Disposition (Name of cemetery, crematory or other place) King Park 20c. Location - City or Town, State Windsor Mill, MD
	21. Signature of Funeral Service Licensee 22. Name and Address of Facility Vaughn C. Greene F. S. 4905 York Road Baltimore, MD 21212 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Approximate Interval
Physician /Medical Examiner	Failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Due to (or as a consequence of): Between Onset and Death Due to (or as a consequence of):
iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause c
scuted and transit	(Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): d.
760, cicate be executed the burial - transit	
P.O. Box 687 s that the death certification of the attending pred by the attending perfected for use as the by Physician/I	23b. Was decedent pregnant in the past 12 months? 1 Live birth 2 Fetal death 3 Ectopic pregnancy Month Day Year 4 Pregnant at time of death 5 Other (Specify) g Unknown
ires that the signed by the detacher	1 Yes 2 ✔ No 3 Probably 4 Unknown
Division of Vital Records, P.O. Box 687. To the Hospital or Attending Physician: The law requires that the death certifica within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending p completely filled in by the funeral director, page 2 should be detached for use as the ledical Certification: To Be Completed by Physician/I	24a. Was an autopsy findings available prior to completion of cause of death? 1 V Yes 2 No 1 Yes 2 No
certific rector, p	25. Was case referred to medical examiner?
f Vid	1 Yes 2 No 1 Impatient 2 Ervoupatient 3 DOA 4 Indisting Notice 3 No 128a Date of Injury 28b Time of Injury 28c Injury at Work? 28d Describe how injury occurred
on o ath. rr. Aft he fune tion:	1 Natural 5 Pending Apr 11, 2011 1 1 Yes 2 № No Subject shot
Division o spital or Attending tours after death. neral Director: After filled in by the fure Certification:	2 Accident Investigation 3 Suicide 6 Could not be determined 1 Specify Local Street 1 Street 1 Street 1 Street 1 Street 2 Street
Division of Vital Rec To the Hospital or Attending Physician: The I within 24 hours after death. To the Funeral Director: After this certificate completely filled in by the funeral director, page Medical Certification: To Be Con	
	O.C.M.E. April 11, 2011
1	30. Name in laddress of person who completed cause of death (Item 23a) Laron Locke MD. Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201
State Registra	

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend #26 Per PHY G914 4/15/2011 JH State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death April Physician/ 8:05 Ам Ann Cooper 2011 . Medical 4c. County of Death 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** Baltimore Old Harford Road Parkville If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. 5. Social Security Number 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) 8. Date of Birth **Funeral** Months Month, Day, Year)
April 5, 1916 Dupont, 95 219-42-2366 Director Usual Residence of Decedent 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location with the Maryland iral", or items 23a or 28a-f sho Examiner must be notified at Director MD Baltimore Parkville 1 Yes 2 X No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Completed by Funeral 8733 Old Harford Road 21234 United States 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, 11 Marital Status Armed Forces?

1 X Yes 2 No
If Yes, Give 1 Never Married 2 Married WWII 1 ☐ Yes 2X No Specify: Specify: White "natural" 3 X Widowed 4 ☐ Divorced Year or Dates the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Hospital Elementary/Seconday (0-12) College (1-4 or 5+) and Mental Hygiene. is marked other tha Nurse 12 permit, Page 1 and 2 should be filed w Department of Health and Mental Hygi Important: If item 27 is marked other any injury or other traumatic event, ? Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Maryland ည Michael Koban Mary Baybovic 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) John Cooper/ Son 8733 Old Harford Road, Parkville, MD 21234 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State April 16, cemetery, crematory or other place)
Evans Funeral
Chapel – Bel Air 1 🔲 Burial 2 💢 Cremation 3 🗆 Removal from State Forest Hill, MD 4 ☐ Donation 5 ☐ Other (Specify) 2011 22. Name and Address of Facility
Evans Funeral Chapel & Cremation Services
8800 Harford Rd. Parkville, MD 21234 Signature of Funeral Service Licensee 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Serile DemontiA Immediate Cause (Final Physician/ Medical resulting in death) Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to for as a consequence of, Cause (Disease or linjury that initiated events resulting in death) Last or Attending Physician: The law requires that the death certificate be executed the burial-transit and Due to (or as a consequence of) attending physician Physician/Medical Division of Vital Records, P.O. Box 68760 use as IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnar 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No 5 Other (specify) Pregnant at time of death been signed by the a should be detached t 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? à rebro VACGIAr 1 🗌 Yes 2 Probably 4 ☐ Unknown Completed Afheriseleratie cardioursalar 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an has page 2 autopsy DUSTA SE certificate 25. Was case referred to medical 26. Place of Death (Check only one) funeral director, Be examiner's Other: 4 Nursing Home Hospital: 1 ☐ Yes 2 ☐ No Residence ပ 1 Inpatient 2 ER/Outpatient 3 DOA this 28a. Date of injury (Month, Day, Year) 28c. Injury at work?
1 ☐ Yes 2 ☐ No 27. Manner eath 28b. Time of Certificate: 28d. Describe how injury occurred 1 atural
2 Accident 5 Pending Investigation completed filled in by the within 24 hours after deat To the Funeral Director: 6 Could not be Suicide 3 ☐ Suiciae4 ☐ Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) Hospital Medical * Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examine: On the basis of examination and/or investigation, in my opinion, death place and place, and due to the cause(s) and manner stated.

3 Certifying Nurea Fractionar: To the cause of any module of a state of the cause of the (Check 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) D15871MD. 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 1734 York Rd Luyhenille Md 21093 LAWRENCE BOAS MD 31. Date filed (Month Pr. Year) 5 2011 3 Registrar's Signature Registrar

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	State of Maryland / Department of Health and	d Mental Hygiene

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		- For State Registrar	,		Certific	ate of	Death			R	eg. No.	, ,	
Physician	1	Decedent's Name (First, Midd	die,Last)							Date of Dea Month	Day Ye	ar	3. Time of Death 1052 hrs
Medical Examine		PHILIP 4a. Facility Name (if not instituti	W.				E, III	Location		April 10, 2	4c. County	of Death	
		Sinai Hospital	ion, give street and	number)		"	Baltimore	Location				N/A	
Funeral	1	5. Social Security Number	6. Sex	7. Age (II	n yrs, last birt	hday)	If Under 1 Yea Months Day	_	_			Y) 9. Birt Foreig	hplace (State or n Kansas untry)
Director	L	216-48-3689	1 M 2 F		67	Yrs.	lilonario Bay	5 110013		Jan 31	, 1944	Cou	untry) Railisas
Å		Usual Residence of Decedent 10a. State 10b. County	,	100	c. City, Town	or Locatio	n						10d. Inside City Limits
B 100 M	Ι,		N/A		•	imore							1 X Yes 2 No
the Maryland or 28a-f show	֓֓֓֓֓֓֓֓֓֓֓֓֓֓֓֓֓֓֓֓֓֓֓֓֓֓֓֓֓֓֓֓֓֓֓֓֓	Maryland 10e. Street and Number	IV/ ft		Dair		10f. Zip Code			1	0g. Citizen of W	hat Cour	ntry?
11215-0036 Id be filed within 72 hours after death with the Maryland Aental Hygiene. sarked other than "natural", or items 23a or 28a-f sho event, the Medical Examiner must be notified at once.	5	1803 Thornbu	ry Road				21	L209		İ	US	A	
ath with the litems 23a or ust be notified	5	11. Marital Status		ecedent Eve	er in U.S.		Decedent of His					e - Americ	can Indian, Black,
r death with or items 23		1 X Never Married 2 N	1 Yes	2 X	No	_			, r donto re	iouri, oto.)		-	ita
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21215-0036 hould be filed within 72 hours after ind Mental Hygiene. is marked other than "natural", rite event, the Medical Examines.		Elementary/Secondary (0-12)		(1-4 or 5+)			st of working life						
036 ithin 7 ne. Iedica		N/A					N/A					[/A	
Hygie W		17. Father's Name (First, Middle		-							Maiden Surname	e)	
ID 21215-005, should be filed with and Mental Hygiene and marked other it is marked other to natic event, the Mes		Philip Will 19a. Informant's Name/Relation		e, Jr		Mailing .	Address (Street			Jane En	ISOL nber, City or Tov	vn State	Zin Code)
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More Pages 1 nent of H ant: If ii	ı	1 Burial 2 Cremation		from State				tery	4/15	5/2011	Pikesv	ille	, Maryland
Baltimore, ME permit. Pages I and 2 s Department of Health at Important: If iten 27 injury or other traum.	ŀ	4 Donation 5 Other S 21 Signature of Funeral Service									L HOME, Maryl		
E L C E	1	Martin D. Law	son										
Physician /Medical	1	23a. Part I. Enter the disease, o failure. List only one cause	e on each line.						ardiac or r	respiratory arr	est, shock, or he	art	Approximate Interval Between Onset and Death
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	•	if any, leading to immediate cause. Enter Underlying Cause	Due to (or as	a consequ	ence of):								
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certificate be anding physici		IF FEMALE: 23b. Was decedent pregnant in the past 12 months?	44-		of pregnancy	Feta	I death 3	Ectopic	c pregnanc	су	Month		Day Year
Box 68 e death certif the attending ed for use as			nlen mum	gnant at tim	e of death	Othe	er (Specify)						
		Part II. Other significant condi	90111	nown to death bu	ut not resultin	g in the un	derlying cause	given in Pa	art I.	23e. Did to	obacco use cont	ribute to	the cause of death?
Division of Vital Records, P.O. tal or Attending Physician: The law requires that the start death. **Al Director: After this certificate has been signed by lied in by the funeral director, page 2 should be detact or differentiation: To Be Commission by the fine of the contribution of the commission by the contribution of the commission by the contribution of the commission by the contribution of the commission by the contribution of the cont	<u>`</u>	_								1 Yes	s 2 ✓ No 3	Prob	pably 4 Unknown
Records, The law require. ficate has been sign, page 2 should be										24a. Was			topsy findings available completion of cause of
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F Vita	2 L	examiner? 1 ✓ Yes 2 No	Hospital: 1	Inpatient	2 🗹 ER/O			Other ₄			Residence 6		
		27. Manner of Death 1 X Natural 5 Per	(Mo	te of Injury nth, Day,Year)	28b.	Time of Inj		ıryatWork Yes 2 ☐		Rescribe	how injury occur	red	
Sion Attendath r death ector: by the	5		nding estigation	ace of Injury	- At home for	arm street	factory, office I			98f Location (Street and Numb	per or Ru	ral Route Number, City
Division o spital or Attending nours after death cours after death filled in by the fune			uld not be (Special		- At riome, is	arri, street	, ractory, office i	ballaling, or		or Town, S		70.0.1	.a. ribato ri aribar, any
Pon Pon C		29a. Certifier 1 Certifying F	Physician: To the b	est of my kr	nowledge, de	ath occurre	ed at the time, d	ate and pla	ace, and d	lue to the caus	se(s) and manne	er as state	ed.
Division of Vital Records. To the Hospital or Attending Physician: The law requirent in 24 hours after death. To the Funcral Director: After this certificate has been completely filled in by the funeral director, page 2 should be director.	5	one) 2 Medical Ex	aminer: On the bas and manne	is of examin r stated.	ation and/or i	nvestigatio	on, in my opinior	n, death oc	curred at	the time, date	and place, and	due to the	e cause(s)
F 3 F 3	Ĕ	29b. Signature and title of certif	fier	0			29c. Licens				29d. Date sign	•	nth, Day, Year)
		Carde	-Hal	la			0.0.	.M.E.			April 11, 2		
DK.D		 Name and address of perso Carol Allan, MD As 	on who completed ca ssistant Medica			Penn S	treet, Baltim	ore, MD	21201				
Stat	Œ	31. Date filed (Month, Day, Year		Registrar's									
Registra	ar_	APR 1 5 2011	Densur	A.	Marke	1							
DHMH 17 Rev 1/200	1		OGME		OF	RIGINAL	i .						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death A PRI Physician/ NDRE 011 Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner CHESAPEAKE HARFORD Bel Air 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign Social Security Number Funeral Days Hours Min Country)
Maryland 1 □ M 2 🔀 F 217-64-4137 Yrs. Director 958 Usual Residence of Decedent or 28a-f shov 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits other traumatic event, the Medical Examiner must be notified at Director 1 🗌 Yes 2 🔀 No Maryland Harford Joppa 10f. Zip Code 10e Street and Number 10g, Citizen of What Country? Funeral or items 23a 104 Beacon Point Ct. 21085 USA hours after death 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11 Marital Status Armed Force Black, White, etc. ģ 1 XNever Married 2 Married 1 ☐ Yes 2 🔀 No Maryland 21215-0036 1 Yes 2 No Specify: If Yes, Give "natural", 3 Divorced Completed White Year or Dates 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry within 72 al Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) 12 Beautician Hair Salon Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) nd Mental F Henry Frank Culotta Peggy Lee Phillips permit. Page 1 and 2 should Department of Health and M. Important: If item 27 is mark any injury or other traumati 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 104 Beacon Point Ct., Joppa, Peggy Culotta / Mother Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State 4-13-11 4 Donation 5 Other (Specify) Parkwood Cemetery Baltimore, Maryland Signature of Function Service Licenses 22. Name and Address of Facility McComas Funeral Home, P.A. 1317 Cokesbury Road, Abingdon, Maryland 21009 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate shock, or heart failure. List only one call on each line. Interval Between Onset and Death Immediate Cause (Final disease or condition IVF Physician/ Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events resulting in death) Last Examine Due to (or as a consequence of) been signed by the attending physician and should be detached for use as the burial-transit Due to (or as a consequence of): Completed by Physician/Medical Box 68760 IF FEMALE 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months?
1 ☐ Yes 2 ☐ No Year Month Day 1 ☐ Yes ∠ ☐ 9 ☐ Unknown 9 Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? JAUNDICE RUCTIVE Records, 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performed? Yes 2 2 No 1 Yes 2 No Physician: Vital Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? 2 No Hospital Other: | XInpatient 2 ER/Outpatient 3 DOA ျ 1 Yes 4 Nursing Home 5 Residence 6 Other (Specify) of 27. Manner of Death 28a. Date of injury 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred al or Attending P s after death. Il Director; After t 1 Natural (Month, Day, Year) work? 1 ☐ Yes 2 ☐ No injury 5 Pending Division Accident Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) To the Hospital or within 24 hours a To the Funeral D 1 X certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) Manista 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) VP, MAN SHA BAHL, MD 500 VPPER

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State Registrar 31. Date filed (Month, Day, Year)

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32. Registrar's Signatur

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene, For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 11: 40 AM Robert Carter, Sr. 04 2011 Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner N/A Baltimore Union Memorial Hospital 9. Birthplace (State or Foreign 5. Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth 6. Sex 7. Age (In vrs. last birthday) **Funeral** (Month, Day, Feb 2 Days Hours So. Carolina 1 □_XM 2 □ F Director 78 249-46-7223 Usual Residence of Decedent should be filed within 72 hours after death with the Maryland and Mental Hygiene. is marked other than "natural", or items 23a or 28a-f show aumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 No Baltimore Maryland N/A 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? by Funeral U.S.A 21208 1015 Scotts Hill Drive 12. Was Decedent Ever in U.S Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Armed Forces Black, White, etc. 1 Never Married 2 Married 1 Yes If Yes, Give 2 XNo Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: Black Specify: 3 Nidowed 4 Divorced Completed Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15 Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Danko Arlington & Koppers Molder Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Bessie Carter Cal Carter permit. Page 1 and 2 should be Department of Health and Ment Important: If item 27 is marke any injury or other traumatic once. traumatic 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1015 Scotts Hill Drive Baltimore, Maryland 21208 Jennifer Carter 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place) 1 KBurial 2 Cremation 3 Removal from State Windsor Mill, Md. 04/14/11 King Memorial Park 4 ☐ Donation 5 ☐ Other (Specify) . Signature of Funeral Service Licenses 22. Name and Address of Facility Estep Brothers Funeral Service, P 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician rostal Can Cer disease or condition resulting in death) tatic tas Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions Examine if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of) Hospital or Attending Physician: The law requires that the death certificate be executed as the burial-transi Cause (Disease or iinjury and that initiated events resulting in death) Last Due to (or as a consequence of) attending physician Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?
1 ☐ Yes 2 ☐ No Pregnant at time of death page 2 should be detached Unknown signed by the Unknown Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ٥ 1 Yes 2 No 3 Probably 4 Unknown Completed has been Were autopsy findings available prior to completion of cause of death? 24a, Was an autopsy 1 🗌 Yes 2 🗌 No After this certificate 25. Was case referred to medical completed filled in by the funeral director, Be 26. Place of Death (Check only one) examiner? Other: 잍 1 Inpatient ER/Outpatient 4 Nursing Home 5 Residence 6 Other (Specify 28c. Injury at work? 27. Manner of Death 28a. Date of injury 28b. Time of Certificate: 28d. Describe how injury occurred (Month, Day, Year) 1 Watural 5 Pending 1 Tes 2 No death. Accident Suicide after death Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) ☐ Homicide determined 24 hours Medical Destrifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated within 2 To the I 29b. Signature and title of certifier M.D. April, 8th, 2011 D006774 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Baltimore, MD 21218 Bar Union Memorial Hospital Walid bour, 31. Date filed (Month, Day, Year, 32. Registrar's Signature State Registrar

DHMH 17 Rev 7/2009

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiener For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month 55 M Daniel W. Colie, Jr. L Medical 4a. Facility Name (if not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner Square HOSPIta Rosedale ranklin If Under 1 Year If Under 24 Hrs. Social Security Number 7. Age (In vrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign Funeral 1 🛣 M 2 🗆 F Months Days Hours Min. Country) Director 1/28/195 North Carolina 215-56-1940 Usual Residence of Decedent or 28a-f shov 10a. State 10b. County 10d. Inside City Limits permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If them 27 is marked other than "natural", or items 23s or 28s-f sho any injury or other traumatic event, the Medical Examiner must be notified at 10c. City, Town or Location Director 1 Yes 2 X No MD Harford Joppa 10f. Zip Code 10e, Street and Number 10g. Citizen of What Country? Funeral 363 Blackburn Place 21085 USA 13. Was Decedent of Hispanic Origin? (Specify Yes or No-12. Was Decedent Ever in U.S. 14. Race - American Indian. 11. Marital Status Armed Forces?

1 Yes 2 X No Yes, specify Cuban, Mexican, Puerto Rican, etc. Black, White, etc. ģ 1 Never Married 2 Married Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 🙀 No Specify: Specify: 3 Widowed 4 X Divorced White Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Guard Security Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) မ Dorothy L. Owens Daniel W. Colie, Sr. 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Napa, California 94558 Diana Schipper (sister) Emperor Way Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date ☐ Burial 2 🔀 Cremation 3 ☐ Removal from State Donation 5 Other (Specify) Louse Crematory Service 4/14/2011 Greenville, N.C. 21. Signath of Funeral Service Licenses 22. Name and Address of FacilityDuda-Ruck Funeral Home of 7922 Wise Ave. Dundalk, MD. 21222 Dundalk, Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ Can disease or condition resulting in death) ung Medical Due to (or and consequence of): Examiner Sequentially list conditions, Examine Due to (or es a consequence of): if any, leading to immediate cause. Enter Underlying the Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and I for use as the burial-transit Cause (Disease or iinjury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
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1 Yes 2 No 24 hours after deatn.

• Funeral Director After this certificate has I 1 Yes 2 No 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Other: 1 🗌 Yes 2 🔀 No ၉ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) Date of injury (Month, Day, Year) 28c. Injury at work? 1 ☐ Yes 2 ☐ No Manner of Death 28b. Time of Certificate: 28d. Describe how injury occurred 1 Natural injury 5 Pending 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a, Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. within 2 To the F only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 00053694 30, Name and address of person who completed cause of death (Item 23a) (Type, Print) 100 Franklin Square Drive Baltimore 31. Date filed (Month, Day, Year) State APR 15

DHMH 17 Rev 7/2009

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene. For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Physician/ 201 Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death 4b. City. Town, or Location of Death **Examiner** butimore baetimore Age (In vrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1**火** M 2 □ F Months Days Hours Min. (Month_Day, Maryland Director 213-32-0889 Oct Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f shot any injury or other traumatic event, the Medical Examiner must be notified at 10b. County 10d. Inside City Limits 10a. State 10c. City, Town or Location Director MD Baltimore Parkville 1 🗌 Yes 2 😾 No 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? Funeral 8710 Emge Road 21234 USA 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14 Bace - American Indian. 11. Marital Status Armed Forces?

1 X Yes 2 \(\square\$ No Black, White, etc. þ 1 X Never Married 2 Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 ☐ No Specify: white Completed 3 Divorced 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business Industry life. DO NOT use retired) University Of Elementary/Seconday (0-12) College (1-4 or 5+) 12 Maryland CPA Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Charles Clifford Davis Anne Brooks McLaughlin 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Donald Davis-brother 8624 Hoerner Avenue-Parkville, Maryland 21234 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place)
Evans Funeral Chapel ar 1 Burial 2 Cremation 3 Removal from State Forest Hill, Maryland 4 ☐ Donation 5 ☐ Other (Specify) Signature of Funeral Service Licensee 22 Name and Address of Facility
Evans Funeral Chapel and Cremation Services andra 8800 Harford Road-Parkville Maryland 21234 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition Medical resulting in death) as a consequence of Examiner Esquentially list conditions, if any, leading to immediate cause. Enter Underlying Examine attending physician and for use as the burial-transit Cause (Disease or iinjury that initiated events resulting in death) Last To the Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a cons Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Day Year Month 5 Other (specify) page 2 should be detached the been signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 X Unknown Completed 24b. Were autopsy findings available 24a. Was an prior to completion of cause of death?

1 Yes 2 No has certificate Yes filled in by the funeral director, 25. Was case referred to medical Be | 26. Place of Death (Check only one) examiner? Hospital: Other: 1 Tyes 2 **X** No 4 Nursing Home 5 Residence 6 Other (Specify) ျှ 1 Inpatient 2 ER/Outpatient 3 DOA within 24 hours after death.

To the Funeral Director: After this 28a. Date of injury (Month, Day, Year) Certificate: 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending 1 Yes 2 No Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one 29b. Signature and fitle of certifier 29c. License number 29d. Date signed (Month. Dav. Year) 30. Name and address of person who completed caus of death (Item 23a) (Type, Print) Bartinge, mo 21133

Registrar
DHMH 17 Rev 7/2009

State

31. Date filed (Month, Day, Year)

APR

15

Registrar's Sign

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygieney For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death 3:34 Рм Physician/ Erika Maret Desell April 2011 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Upper Chesapeake Medical Center Harf ord BelAir Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign 6. Sex **Funeral** July 23. 1 □ M 2X Days Hours Min. 216-54-6083 61 Germany Director Usual Residence of Decedent ms 23a or 28a-f show must be notified at 10c. City, Town or Location 10d. Inside City Limits permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho any injury or other traumatic event, the Medical Examiner must be notified at 10a. State 10b. County Director Harford Fallston MD 1 ☐ Yes 2X No 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? Funeral 21047 United States 316 Mountain Road Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Was Decedent Ever in U.S. Race - American Indian. Armed Forces?

1 Yes 2 No Black, White, etc. 1 Never Married 2 X Married Completed by Maryland 21215-0036 1 ☐ Yes 2 X No Specify: White 3 Widowed 4 Divorced Year or Dates 15. Decedent's Education 16a, Decedent's Usual Occupation 16b. Kind of Business Industry Give kind of work done during most of working (Specify only highest grade completed) life. DO NOT use retired) College (1-4 or 5+) Elementary/Seconday (0-12) Pharma cy Pharmacist 12 Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မှ Walter Simon Steck Heldie Arulaid 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Susan Desell-Daughter-in-law 505 Anchor Drive, Joppa, Maryland 21085 Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place)
Evans Funeral
Chapel- Bel Air 20a. Method of Disposition 20c. Location - City or Town, State Aprîf 14 1 D Burial 2 X Cremation 3 D Removal from State Forest Hill, MD 2011 4 Donation 5 Other (Specify) Chape 1 _Ai 22. Name and Address of Facility Evans Funeral Signature of Funeral Service Lice's Chapel Forest Cremation Service Dr. Newport arf 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, hock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death ediate Cause (Final ase or condition Physician/ -UN6 Medical ulting in death) Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate Examiner Due to (or as a consequence of): Hospital or Attending Physician: The law requires that the death certificate be executed 24 hours after death. the attending physician and hed for use as the burial-transit Cause (Disease or linjury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?

1 Yes 2 No Day Month Year Pregnant at time of death 1 Yes 2 Unknown been signed by the should be detached Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Dably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a, Was an After this certificate has autopsy performed 1 Yes 2 No 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 1 Yes 2 NO |은 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending 1 Yes 2 No Accident Suicide Investigation To the Funeral Director: completed filled in by the 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide To the Hospital within 24 hours a To the Funeral D Medical 1 certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title o 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 500 mo State Registrar

Donald Alfred Domain, Jr.

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Donald Amed Dom	1- For State Registrar		ite of Death	Reg.		12601
Physician/ Medical Examine	Decedent's Name (First, Middle,Last)	Domain, Jr.			Day Year	3. Time of Death 1349 hrs
IN-CICAL EXAMINE	4a. Facility Name (if not institution, give s		4b. City, Town, or Location of D	April 9, 2011 Death	4c. County of Death	10.10.1110
	4406 Bartholow Road		Sykesville		Carroll	
Funeral Director	5. Social Security Number 6. Sex	7. Age (In yrs. last birth	day) If Under 1 Year If Under 2 Months Days Hours	4Hrs. 8. Date of Birth (Min. Aug. 15	(MM/DD/YYYY) 9. Birth Foreign Cour	MD
Director	215-40-8673 1XM	2□F 68	Yrs.	Aug. 15) 1942 Cour	ntry) 11D
kig	10a. State 10b. County	10c. City, Town o				Od. Inside City Limits
land f show	MD Carroll	Sykesvi				1 Yes 2 No
the Maryland a or 28s-f sh iffied at ones	10e. Street and Number 4406 Bartholow Ro	ad	10f. Zip Code 21784	10g	. Citizen of What Count USA	γ?
		Was Decedent Ever in U.S.	13. Was Decedent of Hispanic Origin'	? (Specify Yes or No-	14. Race - America	an Indian, Black,
or items 23	1 Never Married 2 Married	Armed Forces?	If Yes, specify Cuban, Mexican, Po	uerto Rican, etc.)	White, etc.	
s after ral", o		Dates:	1 Yes 2 No specify:	d at wards dans d	Specify: White	
2 hours		College (1-4 or 5+)	ecedent's Usual Occupation (Give kin uring most of working life. DO NOT us	e retired)		
5-0036 led within 72 hour dygiene. other than "natu	. 12		levision engineer		Md. Public	TV
15-0 filed w Hygie dothe		oin Cr		Name (First, Middle, Ma nce Eileen		
MD 21215-0036 to 2 should be filed within 7 lith and Mental Hygiene. In 77 is marked other than aumatic event, the Medical To Be Comple	Donald Alfred Dom 19a. Informant's Name/Relationship (Type	e, Print) 19b.	Mailing Address (Street and Number	er or Rural Route Numbe	er, City or Town, State,	Zip Code)
MD 12 sho 127 is 127 is umati	Leah Paul (daughte		Lynbrook Dr. Sou			
ore, and or Heal	20a, Method of Disposition 1 Burial 2 X Cremation 3	Removal from State cremato	Disposition (Name of cemetery, ry or other place)		20c. Location - City or T	
Baltimore, permit. Pages I at Department of Her Important: If ite	4 Donation 5 Other Specify: 21. Signature of Funeral Service Licensee	1 1 - 1	ic Crematory 4 22. Name and Address of Facility		Glen Burnie	
Bal permi Depar Impo injury	Para Jarght Ste		P.O. Box 195 Syk	esville, MI	D 21784	Onaper
Physician	23a. Part I. Enter the disease, or complicate failure. List only one cause on each	tions that caused the death. Do not	enter the mode of dying, such as card	liac or respiratory arrest	t, shock, or heart	Approximate Interval Between Onset and
/Medical	Immediate Ceuse (Final disease a. A	lcoholism				Death
	b	e to (or as a consequence of):				100
ner	Sequentially list conditions, if any, leading to immediate Du cause. Enter Underlying Cause	e to (or as a consequence of):		-		
tam i	(Disease or injury that initiated events resulting in death) Last	e to (or as a consequence of):				
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60, ate be executed bysician and te burial - transit Medical Examiner	☑ UNPENDED ☐ A		me,g915 6-3-11 sm	· · · · · · · · · · · · · · · · · · ·	23d. Date of delivery	
3876 rtificat ling ph as the		23c. If yes, outcome of pregnancy 1 Live birth 2	Fetal death 3 Ectopic p	regnancy	Month Da	y Year
D. Box 687 The death certific By the attending the down as the d	1 Yes 2 No 9 Unknown	4 Pregnant at time of death 5	Other (Specify)			
Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial - transitedical Certification: To Be Completed by Physician/Medical Ex	Part II. Other significant conditions co		in the underlying cause given in Part I	. 23e. Did toba	acco use contribute to the	e cause of death?
s, P.C.		·			2 ✓ No 3 Proba	
ords w request seems been standed				24a. Was an autopsy	prior to co	psy findings available mpletion of cause of
ital Records, ician: The law require. s certificate has been signed to page 2 should be Completed				performe 1 ✓ Yes 2		2 No
ital Reiniclan: The s certificate irector, page	25. Was case referred to medical examiner?	pital: 1 Inpatient 2 ER/Ou	26 Place of Death (Chapatient 3 DOA Other N		esidence 6 🗸 Other:	Scene
of Vina Physical After this uneral dir.	1 Yes 2 No	To an patient 2 21000	ime of Injury 28c. Injury at Work?	28d. Describe hov		300,10
Division of Vapital or Attending Papital or Attending Papital or Attending Papital Director: Affer tilled in by the funeral Certification: T	1 X Natural 5 Pending 2 Accident Investigation	(Month, Day, Fear)	1 Yes 2 No	•		
ivis or At after d Direct J in by	3 Suicide 6 Could not be determined		m, street, factory, office building, etc.	28f. Location (Stre or Town, Stat	eet and Number or Rura te)	I Route Number, City
lospita 1 hours uneral dy fille	298, Celullet 4	(Specify)	h occurred at the time, date and place	and due to the cause/s	s) and manner as stated	
To the Hos within 24 h To the Fux completely	one) 2 Medical Examiner: O		vestigation, in my opinion, death occur			
Z S E S S	29b. Signature and title of certifier	Marinor states.	29c. License number		29d. Date signed (Mont	h, Day, Year)
	Margarite One	Krill	O.C.M.E.		April 10, 2011	
OK and	30. Name and address of person who con Margarita Korell MD. Assis		111 Penn Street, Baltimore, I	MD 21201		
State	31. Date filed (Month, Day, Year)	32 Registrar's Signatura				
Registra	APR 1 5 2011	Devera S. A	barles			
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene-Certificate of Death 3. Time of Death 2. Date of Death . Decedent's Name (First, Middle, Last) Month 2011 Physician/ 04 Medical 4c. County of Death 4a. Facility Name (if not institution, give stre 4b. City, Town, or Location of Death Examiner Medica More 9. Birthplace (State or Foreign Country) unk 5. Social Security Numberunk 8. Date of Birth . Age (In yrs. last birthday) If Under 24 Hrs If Under 1 Year **Funeral** Apr 21, 1941 Min. 1 X M 2 □ F 69 Yrs Director Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must he nexistant once. 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County Director 1 X Yes 2 No Baltimore MD 10g. Citizen of What Country? unk 10e, Street and Number 10f. Zip Code Funeral 21202 234 Bethel Avenue 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 12. Was Decedent Ever in U.S. 11. Marital Status Black, White, etc. Armed Forces? unk þ 1 Never Married 2 Married 1 Yes If Yes, Give Baltimore, Maryland 21215-0036 white 1 ☐ Yes 2 X No Specify. 3 Widowed 4 Divorced Completed Year or Dates 16b, Kind of Business Industry 16a. Decedent's Usual Occupation unk 15 Decedent's Education unk (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) College (1-4 or 5+) Elementary/Seconday (0-12) unk Be 18. Mother's Name (First, Middle, Maiden Surname) 17 Father's Name (First, Middle, Last) unk unk ပ္ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 21202 301 St. Paul Place Baltimore, MD Mercy Medical Center 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 🛛 Other (Specify) in state State Andromy a Board 655 W. Baltimore Street Signature of Funeral Service Licensee 21201 MDtimore, Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final SCASIS Pnysician/ disease or condition Medical resulting in death) Due to (or as a consequence of) Unknown **Examiner** adenocuscinona static Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events resulting in death) Last Examine Due to (or as a consequence of) To the Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-transi Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy
5 Other (specify) in the past 12 months?

1 Yes 2 No Month Day Pregnant at time of death cate has been signed by the page 2 should be detached 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II, Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 Munknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 ☐ Yes 2 ☐ No certificate 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 잍 After this Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 28c. Injury at Certificate: work? 1 Yes 2 No iniury 1 Natural 5 Pending Investigation Accident To the Funeral Director: completed filled in by the Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined within 24 hours a To the Funeral D Medical 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier 01 Residen 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

State

Registrar

Medical

5

31. Date filed (Month, Day, Year)

Registrar's Signatur

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ 201^{rea} Haze1 May Ellis April 1:30 Α. Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death 3045 Pinewood Avenue Baltimore . Social Security Number 8. Date of Birth Month, Day, Y April 13 7. Age (In vrs. last hirthday) If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) Funeral Days Hours 1 □ M 2 💢 F ^(ear) 1923 Director 166-20-5501 88 Pennsylvania Usual Residence of Decedent show 10a, State 10b. County iral", or items 23a or 28a-f sho Examiner must be notified at 10c. City, Town or Location Director 1

Yes 2 □ No Maryland N/A Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 3045 Pinewood Avenue 21214 death v 12. Was Decedent Ever in U.S. Armed Forces?
1 ☐ Yes 2 ☒ No If Yes, Give 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. ģ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 72 hours after 1 ☐ Yes 2X No Specify: "natural", Completed 3 X Widowed 4 Divorced White Year or Dates the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) Page 1 and 2 should be filed within 72 ment of Health and Mental Hygiene. ant: If item 27 is marked other than ' Elementary/Seconday (0-12) College (1-4 or 5+) 12 years Homemaker Own Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Gavlord Crum Helen. 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Marlene Bryan (daughter) 3045 <u>Pinewood Avenue Baltimore, Marvland</u> 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State permit. Page 1 a
Department of IImportant: If ite
any injury or ot Date cemetery, crematory or other place) 1 💢 Burial 2 □ Cremation 3 □ Removal from State 4 Donation 5 Other (Specify) 4-16-11 Elmira, New York Woodlawn Cemetery . Signature of Funeral Service Licensee 22. Name and Address of Facility
Mitchell-Wiedefeld Funeral Home, Inc.
6500 York Road Baltimore, Maryland 21212 23a. Part 1. Briter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Immediate Cause (Final Onset and Death Physician/ ENTIA disease or condition Medical resulting in death) Due to (or as a cor uence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Physician/Medical Examiner Due to (or as a consequence of): the Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or linjury that initiated events attending physician and for use as the burial-tran Due to (or as a consequence of) resulting in death) Last Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) in the past 12 months?

1 Yes 21 No Month Day Year Pregnant at time of death g Unknown as been signed by the 2 should be detached g Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by dia BETES MEILITUS 1 Tes 2 To 3 Probably 4 Unknown nertension 24b. Were autopsy findings available prior to completion of cause of death? 24a, Was an within 24 hours after death.

To the Funeral Director: After this certificate has I completed filled in by the funeral director, page 2 s autopsy performed? 1 ☐ Yes 2 🗗 No Yes 2 No Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) 1 ☐ Yes 2 ☐ No Hospital: Other: ျှ 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at Matural Accident work? 1 ☐ Yes 2 ☐ No 5 Pending Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifier 29c. License number Merri 10 2011 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 5901 North CHAVLES more

DHMH 17 Rev 7/2009

State Registrar 31. Date filed (Month, Day, Year)

Division of Vital Records, P.O. Box 68760 To the Hospital or Attending Ph within 24 hours after death. To the Funeral Director: After th completed filled in by the funeral

Medical

29a. Certifier

31. Date filed (Math, Day, Year) 32. Registrar's Signature State 15 Registrar ✓ DHMH 17 Rev 7/2009

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

5701

🕒 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated

Kenucod

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

21200

29c. License number 31295

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend #14 Per ANA BD C915 5/02/2011 JH State of Maryland / Department of Health and Mental Hygiene | | | | For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month 3^{Day} M PA 7011 Physician/ FLORE JEREMIAH ANGELO Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** MONTGOMERY SILVER SPR 100 6 CROSS OSPITAL If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Months | Days | Hours | Min. | (Month, Day, Year) 9. Birthplace (State or Foreign Country) Social Security Number 6. Sex 1 M M 2 □ F 7. Age (In yrs. last birthday) **Funeral** Months W Director Usual Residence of Decedent or 28a-f shov 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location filed within 72 hours after death with the Maryland the Medical Examiner must be notified at Director 1 ☑ Yes 2 ☐ No PC MARLBOR WD UPPR 10f. Zip Code 10g. Citizen of What Country? 10e, Street and Number items 23a Funeral MEM 207 SA 1202 CI VOWN Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, 11. Marital Status Armed Forces?

1 Yes 2 No Black, White, etc 1 Never Married 2 Married "natural", or þ Hispanic Baltimore, Maryland 21215-0036 1 Yes 2 ☐ No Specify: If Yes, Give Year or Dates Specify: Completed 3 Widowed 4 Divorced NHN 49 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business Industry permit. Page 1 and 2 should be filed within 72 ?
Department of Health and Mental Hygiene.
Important: If feen 27 is marked other than "na any injury or other traumatic event" at a proce. Elementary/Seconday (0-12) College (1-4 or 5+) NFAN NAMI NF Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) ည SANTIAGE $\omega_{\mathcal{P}}$ FLORES - RICO JAZO CHRISTIAN W 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) HOSPIGA RD HOLY CROSS COL EN 500 FOREST 20c. Location - City or Town, State 20a. Method of Disposition 20b. Place of Disposition (Name of Date ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State cemetery, crematory or other place) 4 □ Donation 5 Nother (Specify) in state 22. Strate Armatomy Board 655 W. Baltimore Street 21. Signal Funeral S, rycle Licenses Diractor 21201 Baltimore, MD Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death shock Immediate Cause (Final TRI Physician/ SOM disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner Sequentially list conditions, Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit that initiated events Due to (or as a consequence of) resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Day Year Month Pregnant at time of death 5 Other (specify) 2 🗌 No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a. Was an autopsy performet Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital Other: 2 🛂 No ျပ 1 Tes 4 Nursing Home 5 Residence 6 Other (Specify) 1 Nnpatient 2 -ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred Natural injury work? 5 Pending 1 🔲 Yes 2 No Investigation Accident 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a, Certifier (Check 3 Certifying Nurse Practioner. To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) Signatu 29d. Date signed (Month, Day, Year) re and title of certifie MIS 03 201 102206 30 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) SS. MD ZESSIC 1500 FOREST GLEN RD COGA 32 egistrar's Signature State 1 5 2011 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 10, 2011 Physician/ 10:16 PM **April** Christopher Dennis Geraghty Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Baltimore 17 Gunview Farm Court Perry Hall If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 9. Birthplace (State or Foreign . Age (In yrs. last birthday) 8. Date of Birth . Social Security Numbe **Funeral** 1**X** M 2 □ F Months (Month, Day, Ye ec 30. Country)
Maryland Director 220-72-1079 10a. State 10b. County 10d. Inside City Limits 10c. City. Town or Location death with the Maryland Director 28a-f 1 Yes 2 No Perry Hall MD Baltimore 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? ō 23a Funeral USA 21128 17 Gunview Farm Court Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian. Black, White, etc. Completed by "natural", or 1 Never Married 2 X Married 1 ☐ Yes 2 【XNo If Yes, Give Year or Dates. Page 1 and 2 should be filed within 72 hours after or ment of Health and Mental Hygiene. 21215-0036 1 ☐ Yes 2 X No Specify. Specify: White 3 Divorced 16a. Decedent's Usual Occupation 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) marked other than ' Elementary/Seconday (0-12) College (1-4 or 5+) Energy 12 Computer Operator Be Baltimore, Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Lena Catherine Seitz William Russell Geraghty, Jr. 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) .5 permit. Page 1 and 2 sh
Department of Health ar
Important; If item 27 is
any injury or other trau 17 Gunview Farm Court Perry Hall, MD 21128 Jamie C. Geraghty/wife 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Burial 2X Cremation 3 Removal from State Final Journey Crematory 4/14/2011 Woodbine, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licen Going Home Cremation Service P.O. Box 784 MD 21029 MO1251 Beverly L. Heckrotte, P.A. Clarksville Approximate Interval Between Onset and Death 23a. Part 1. Enter the mease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each lin Cur Cancer Immediate Cause (Final Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of) **Examiner** Sequentially list conditions Examiner Due to for as a consequence of, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events requires that the death certificate be executed physician and the burial-transit Due to (or as a consequence of) resulting in death) Last Be Completed by Physician/Medical Box 68760 attending pl IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregna 5 ☐ Other (specify) Ectopic pregnancy in the past 12 months? Year Month Day Pregnant at time of death ☐ Yes 2 ☐ No g Unknown g 🗌 Unknown P.O. 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an or Attending Physician: The law autopsv certificate has lirector, page 2 performed? 2 🗌 No Yes 2 No Division of Vital 25. Was case referred to medica 26. Place of Death (Check only one) examiner? Hospital Other: 2 1 ☐ Yes 2 💢 No 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at work? 1 ☐ Yes 2 ☐ No 28d. Describe how injury occurred I Director: After t d in by the funera injury 5 Pendina 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) within 24 hours a

To the Funeral I

completed filled To the Hospital Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) April 13, 2011 ullu 0,0, 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Steddo Balthnore, MD 21237 Square Brive man Kao 903 Franklin 32. Registrar's Signature Date filed (Month, Day, Year State Registrar 5 2011

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend item 5 per fh 915 5-16-11 vt State of Maryland / Department of Health and Mental Hygiene | 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 3. Time of Death 2. Date of Death Day 2011 April 14, 2:30 A.M Dorothy Zane Gonzalez 4c. County of Death
Baltimore County 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Apt. 409 Towson 409 Virginia Ave. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 8. Date of Birth 9. Birthplace (State or Foreign March 08, 1923 1 □ M 2 🗗 F Wilmington, DE. 88 155-03-2011 Usual Residence of Decedent 10b. County 10d. Inside City Limits 10c. City, Town or Location 1 ☐ Yes 2X No Baltimore County Towson Maryland 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Apt. 409 409 Virginia Ave. 21286 United States 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No If Yes, Give Year or Dates. 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 No Specify: White 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) 10 <u>Home Maker</u> Own Home N/A 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) George Warrington Hallie Mae Allan

be filed within 72 hours after death with the Maryland lental Hygiene. rked other than "natural", or items 23a or 28a-f shoitic event, the Medical Examiner must be notified at Baltimore, Maryland 21215-0036 Division of Vital Records, P.O. Box 68760

Physician/

Medical

10a. State

Funeral Director

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Completed

Be

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Examiner

Funeral

Director

or 28a-f show

	Mr. Brian G. Gonza. 20a. Method of Disposition 1 Burial 2 Cremation 3 R 4 Donation 5 Other (Specify) 21. Signature of Funeral Service Licensee	lemoval from State Followbrent		nday, (B 1 18,2011 Timo	ution - City or Town, State altimore County nium, Maryland
ouce	John J. g	an / Lic. 10067	7 2325 York Road T	imonium, Maryland	etion Center, P.A. 21093—2215
n/ al er	23a. Port 1. Enter the lisease, or combine shock, or heart failure. List only one Immediate Cause (Final disease or condition resulting in death)	cause on each line.	Do not enter the mode of dying, such as cardia Cardeal Inferco		Approximate Interval Betwee Onset and Dea
Examiner	Sequentially list conditions, if any, leading to immediate cause for Underly S Cause (Disease or inijury that initiated events resulting in death) Last	Due to (or as a consequent			
Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 No 9 ☐ Unknown	ac. If yes, outcome of pregnance 1 ☐ Live Birth 2 ☐ Fetal d 4 ☐ Pregnant at time of dea 9 ☐ Unknown	leath 3 Lectopic pregnancy	23	d. Date of delivery Month Day Year
Completed by F	Part II. Other significant conditions confined to the significant conditions c	tributing to death but not result to previor nellatin, h Hyper	ing in the underlying cause given in Part I. Is stroke, Atreal Lypertonsin Lyndemia	1 ☐ Yes 2 🔀	contribute to the cause of deat No 3 Probably 4 Unit 24b. Were autopsy findings available prior to completion of caus death? 1 Yes 2 No
B	25. Was case referred to medical examiner? 1 Yes 2 No	ospital:	26. Place of Death (Ch		
Certificate: To	27. Manner of Death 1 Natural 5 Pending 2 Accident Investigation		November November November November	Home 5 🔀 Residence 6 🗆 28d. Describe how injury o	
- 14	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of Injury - At home building, etc. (Specify)	e, farm, street, factory, office	28f. Location (Street and N City or Town, State)	lumber or Rural Route Number,
	29a. Certifier Certifying Physic		ge, death occured at the time, date and place, nd/or investigation, in my opinion, death occurred	at the time, date and place, a	nd due to the cause(s) and manne
	(Check 2 Medical Examine	Practioner: To the best of my ki	nowledge, death occurred at the time, date and p		
Medical	(Check 2 Medical Examine only one) 3 Certifying Nurse	Practioner: To the best of my ki			signed (Month, Day, Year)
Medical	(Check 2 Medical Examine only one) 3 Certifying Nurse	Practioner: To the best of my ki			signed (Month, Day, Year) 14/2011 Sommo 2(20

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene U For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death April Physician/ 2011 Year Ana Tulia Gonzalez 9:50a Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Layhill Center Silver Spring Montgomery If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign 5. Social Security Number 8 Date of Birth 7. Age (In yrs, last birthday) Funeral (Month, Day, Year) Oec 28 1 Days 1 □ M 2 🖵 F Director 99 Dec 267-72-3007 1911 Colombia Usual Residence of Decedent 27 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Examiner must be notified at should be filed within 72 hours after death with the Maryland and Mental Hygiene. 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director MD Montgomery 1 ☐ Yes 2 🕅 No Bethesda 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Completed by Funeral 5202 Massachusetts Avenue 20816 USA 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Forces?
1 ☐ Yes 2 🔼 No 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 □XYes 2□No Specify: Colombian hispanic If Yes, Give 3 X Widowed 4 Divorced Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15 Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) housekeeping housekeeper Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ unknown unknown permit. Page 1 and 2 should be Department of Health and Ment Important: If item 27 is marke any injury or other traumatic once. 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Jonathan Dickey (friend) 13850 Forsythe Rd., Sykesville, MD 21784 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other place) 1 Burial 2 X Cremation 3 Removal from State All County Cremation 4-19-11 Sykesville, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Raight Funeral Home & Chapel Signaturer of Funeral Service Licensee P.O. Box 195 Sykesville, MD 21784 400769 23a. Part 1. Enter the disease, or complication that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Physician/ disease or condition resulting in death) Dementia Medical Due to (or as a consequence of): **Examiner** Hypothyroidism Sequentially list conditions Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of) Hospital or Attending Physician: The law requires that the death certificate be executed by the attending physician and tached for use as the burial-transit Chronic Kidney Disease that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Hypertension 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 X No Day Year Pregnant at time of death 5 Other (specify) ate has been signed by the a page 2 should be detached to Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by 1 ☐ Yes 2 Ϊ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an performed' certificate 2 🗆 No 1 ☐ Yes 2 🗓 No 1 Yes To Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 2 🟋 No 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) Certificate: 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 X Natural 5 Pending 1 Yes 2 No 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Division of Vital Records, P.O. Box 68760 within 24 hours after death.

To the Funeral Director: After this certific, completed filled in by the funeral director, I To the I within 2

Registrar

DHMH 17 Rev 7/2009

Justano

Sultana J. Afrooz, M.D.

31. Date filed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 22a) (Type, Print)

D. Q.

H67624

10005 Old Columbia Road, Suite P, Columbia, MD 21046

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygieney For State Registrar Certificate of Death Reg. No. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death 10.44 AM Physician/ Louise Barbara 2011 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Anne Arundel Glen Burnie Baltimore Washington Medical Center Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 🗆 M 2 🔀 Months Days Hours Country) PA August, 14 1934 76 Director 212-34-1234 Usual Residence of Decedent iral", or items 23a or 28a-f show Examiner must be notified at 10d. Inside City Limits 10a. State 10b. County 10c. City. Town or Location Director 1 Yes 2X No Anne Arundel Pasadena 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? Funeral USA 21122 2917 Dungate Road within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White ð 1 Never Married 2 Married White Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify: "natural" Completed 3 X Widowed 4 Divorced Year or Dates the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) permit. Page 1 and 2 should be filed within 72 Department of Health and Mental Hygiene. Important: If item 27 is marked other than any injury or other traumatic event, the Me Elementary/Seconday (0-12) College (1-4 or 5+) Retail Clerk Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Amelia Regina Schliffer Russell Alfred Pope 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2917 Dungate Road Pasadena Maryland 21122 Louise Lloyd-Daughter 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other) 20c. Location - City or Town, State Burial 2 Gremation 3 Removal from State Meadowridge Mem Park Apr 16 2011 Elkridge Maryland 4 Other (Specify) 22. Name and Address of Facility Ambrose Funeral Home Inc ral Service 1328 Sulphur Spring Road Arbutus Maryland 21227 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest Approximate shock, or heart failure. List only one cause on each line Interval Between Onset and Death Immediate Cause (Final OBSTRUCTIVE DISEASE Physician/ CHRONIC PULMONARY Medical resulting in death) Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of) The law requires that the death certificate be executed attending physician and for use as the burial-transit Cause (Disease or iinjury that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Fctopic pregnancy in the past 12 months?

1 Yes 2 No sate has been signed by the atte page 2 should be detached for Month Year 5 Other (specify) Day Pregnant at time of death Part If. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by 1 X Yes 2 No 3 Probably 4 Unknown Division of Vital Records, Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an Was an autopsy performed? within 24 hours after death.

To the Funeral Director: After this certificate I completed filled in by the funeral director, page or Attending Physician: To Be 25. Was case referred to medical 26. Place of Death (Check only one) BAR Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No 1 Tes ER/Outpatient 3 DOA 1 Kinpatient 2 28a. Date of injury (Month, Day, Year) Certificate: 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 X Natural 5 \square Pending work 1 Yes 2 No 2 Accident
3 Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined To the Hospital Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifier 3 🗆 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number 0061219 APRIL 12. 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) GLEN BURNIE MD 21061 HOSPITAL RORA BWMC HARVINDER 31. Date filed (Month, Day, Year) State APR 15 Registrar

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Physician/ 11:16am M 2011 Alice Barnes Hughlett Apri. Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Carroll Hospital Center Carrol1 Westminster 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign Birthpiec Country) MD **Funeral** June 25, 1913 1 □ M 2 ⋤ Months Days Hours Min. **Director** 216-03-5598 97 Usual Residence of Decedent "natural", or items 23a or 28a-f show edical Examiner must be notified at 10a. State 10c. City, Town or Location 10d. Inside City Limits Director MD 1 Yes 2X No Carrol1 Sykesville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 1622 Arrington Road 21784 USA 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Was Decedent Ever in U.S. 14. Race - American Indian. Armed Forces?

1 Yes 2 XNo
If Yes, Give
Year or Dates. Black, White, etc. þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐XNo Specify: White Specify: 3 X Widowed 4 □ Divorced Completed the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) 2 should be filed within 72 lith and Mental Hygiene. 77 is marked other than "r Elementary/Seconday (0-12) College (1-4 or 5+) Clerk Telephone injury or other traumatic event, Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Edward Eugene Barnes Molly Husselbaugh 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 st Department of Health a Important: If item 27 is any injury or other tra Mrs. Dona Jean Makowski (Granddaughter) 1622 Arrington Rd., Sykesville, MD 21784 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Lake View Mem. Park 4/12/2011 Sykesville, MD 22. Name and Address of Facility HAIGHT FUNERAL HOME & CHAPEL, PA 21. Signature of Funeral Service Licenses PO Box 195 Sykesville, MD 21784 MO0764 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line Immediate Cause (Final Heart Physician/ Congestive disease or condition resulting in death) Medical Due to (or sea consequence of): Examiner Sequentially list conditions, if any leading to immediate cause. Enter Underlying Examine Due to for as a consequence of the burial-transit Cause (Disease or iinjury that initiated events resulting in death) Last Due to (or as a consequence of): attending physician Physician/Medical death certificate be IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy
5 Other (specify) in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day Year Pregnant at time of death signed by the at Id be detached fo 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? certificate 1 🗌 Yes 2 🗀 No 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner?
1 ☐ Yes 2 ► No Other: 4 Nursing Home 5 Residence 6 Other (Specify) Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending 1 🗌 Yes 2 🗌 No 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) Medical

Box 68760 P.O. Division of Vital Records, Hospital or Attending Physician: 24 hours after death. To the Funeral Director: After this certific completed filled in by the funeral director, within 24 hours a

> 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Stone are Westminokimo 21157 State Registrar

Cartifying Nurse Fractioner: To the best of my knowledge, de

29a. Certifier (Check

29b. Signature and title of certifier

ertifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated

occurred at the time, date and place, and due to the r

D 52035

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 11-02339 State of Maryland / Department of Health and Mental Hygiene Justin Wayne Hastings 1- For State Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle,Last) Physician/ Month Day March 26, 2011 1254 hrs Modical Examiner ING SLIN 4c. County of Death 4b. City, Town, or Location of Death 4a, Facility Name (if not institution, give street and number) **Baltimore County** Franklin Square Hospital Rosedale If Under 1 Year If Under 24Hrs. 8. Date of Birth(MM/DD/YYYY) 9. Birthplace (State or 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Months Davs Hours Director Usual Residence of Decedent 10d. Inside City Limits 10b. County 10c. City, Town or Location 1 Yes 2 No MI should be filed within 72 hours after death with the Maryland and Mental Hygiene.
77 is marked other than "natural", or items 23a or 28a-f sho matic event, the Medical Examiner must be notified at once. 10g. Citizen of What Country? SWOR 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14. Race - American Indian, Black, Funeral 12 Was Decedent Ever in U.S. 11. Marital Status If Yes, specify Cuban, Mexican, Puerto Rican, etc.) White, etc. Armed Forces? 1 Yes 1 Yes 2 No specify: Specify: WHITE Divorced If Yes, Give Year 3 16a, Decedent's Usual Occupation (Give kind of work done 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Completed during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) 18. Mother's Name (First, Middle, Maiden 17. Father's Name (First, Middle, Last) permit. Pages 1 and 2 should be Department of Health and Menta Important: If item 27 is mark injury or other traumatic even MD E 4 Donation 5 Other Specify. 21. Signature of Funeral Service Licen 22. Name and Address of Facility 21224 made Approximate Interval 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Physician Between Onset and failure. List only one cause on each line Medical Death a Methadone intoxication and oxycodone use kaminer or condition resulting in death) Due to (or as a consequence of) Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of): Examine cause. Enter Underlying Cause (Disease or injury that initiated Due to (or as a consequence of): events resulting in death) Last and The law requires that the death certificate be executed Physician/Medical X UNPENDED AMENDED 23a, 27, 28a-f, per me g915 5-25-11 sm attending physician or use as the burial Box 68760 23d Date of delivery IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant in the Day Year Live birth 2 Fetal death 3 Ectopic pregnancy past 12 months? Pregnant at time of death Other (Specify) Yes 2 No 9 Unknown 9 Unknown signed by the the 23e. Did tobacco use contribute to the cause of death? Records, P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. \$ 1 Yes 2 No 3 Probably 4 ✔ Unknown s been s 24a. Was an 24b. Were autopsy findings available autopsy prior to completion of cause of this certificate has death? performed? 1 🗸 Yes 1 ✓ Yes 2 No 2 No 26. Place of Death (Check only one) 25. Was case referred to medical Division of Vital examiner? Other Nursing Home 5 Residence 6 Other DOA 1 🗸 Yes After the 28a. Date of Injury (Month, Day, Yea 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death Natural 1 Yes 2 X No fd 3-26-11 fd 12:11 pm Accident 28f. Location (Street and Number or Rural Route Number, City 28e. Place of Injury - At home, farm, street, factory, office building, etc. 6 K Could not be Suicide or Town, State) 9000 Franklin Square Dr. Baltimore, Md. determined (Specify) Franklin Square hospital Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 2 Wedical Examiner. On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

To the Hospital or Attending Physician:

Name and address of person who completed cause of death (Item 23a) Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201 Theodore M. King, Jr., MD.

31. Date filed (Month, Day Year) State Registra

29b. Signature and title of certifier

32. Registrar's Signature arke newar

29c. License numbe

O.C.M.E.

OCNE

29d. Date signed (Month, Day, Year)

March 27, 2011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State
Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month 3/5/201 Physician/ Carrie Hettche 10:50p^M Medical 4a. Facility Name (if not institution, give street and number)
2807 Illinois Avenue 4c. County of Death Examiner 4b. City, Town, or Location of Death Halethorpe Baltimore Age (In yrs. last birthday, Social Security Number 1 Year If Under 24 Hrs. 8. Date of Birth Birthplace (State or Foreign Country) **Funeral** 1 🗆 M 2 🔀 F Month, Day, Year) 6/2/1936 Months Director 212-32-5258 MD Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic access. 10a. State 10b. County 10d. Inside City Limits 10c. City. Town or Location Director Baltimore Halethorpe 1 ☐ Yes 2X No 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? Funeral 2807 Illinois Avenue 21227 USA 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. <u>\$</u> 1 Never Married 2 Married 1 Yes 2 No Maryland 21215-0036 White 1 ☐ Yes 2 🔀 No Specify. Specify: Completed 3 X Widowed 4 Divorced Year or Dates 16a. Decedent's Usual Occupation 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life, DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Glass Co. Factory Worker Q, 0 Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Leo Gibson Beulah Galloway 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
r 2807 Illinois Ave, Halethorpe MD 19a. Informant's Name/Relationship (Type, Print) Robin E. Dobbins/Daughter 21227 Baltimore, 20a. Method of Disposition 20h Place of Disposition (Name of 20c. Location - City or Town, State XXBurial 2 Cremation 3 Removal from State Crestlawn Cemetery 3/11/20|11 Marriotsville MD 4 Donation 5 Other (Specify) 21. Signature of Funeral Service Licensee Victor Doda 22. Name and Address of Facility Charles L. Stevens Funeral 1501 E. Fort Ave Baltimore 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Cyncer Physician 0 disease or condition Medical resulting in death) Due to (or as a consequence Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or imjury that initiated events Due to (or as a consequence of) Examine Hospital or Attending Physician: The law requires that the death certificate be executed burial-tran and Due to (or as a consequence of) resulting in death) Last attending physician Physician/Medical Division of Vital Records, P.O. Box 68760 as the l IF FEMALE: asn yes, outcome of pregnancy 23b. Was decedent pregnant 23d, Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ Live Birth 2 Fetal death o in the past 12 months? Month Day Year Pregnant at time of death Yes the ρ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ þe 3 1 1 Tyes 2 No Probably 4
Unknown cate has been siç ; page 2 should b Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate ☐ Yes 2☐ No 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Other: 2 No ည 1 Inpatient 2 ER/Outpatient 3 DOA Funeral Director: After this 27 Manner of Death 28a. Date of injury 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 Natural 2 Accident (Month, Day, Year) 5 Pending 1 Yes 2 No death. Investigation the 3 Suicide
4 Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number completed filled in by within 24 hours after To the Funeral Direc determined City or Town, State) Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only on 29b. Signatu of certifie icense numbe 29d. Date signed (Month, Day, Year)

State Registrar h, Day,

5

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Physician/ 4.16 AM Martha Howard 201 Medical 4a. Facility, Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) If Under 24 Hrs. 8. Date of Birth **Funeral** 1 □ M 2 🔀 F Months Hours Min. Feb. 9, 1925 86 PA 212-22-5405 Director Usual Residence of Decedent or 28a-f show 10d. Inside City Limits 10b. County 10c. City, Town or Location or than "natural", or items 23a or 28a-f sho the Medical Examiner must be notified at 10a. State within 72 hours after death with the Maryland Director 1 Tx Yes 2 ☐ No MD Baltimore N/A 10g. Citizen of What Country? 10f, Zip Code 10e, Street and Number Funeral 1605 South Ellamont St. 21230 USA Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. Black, White, etc þ 1 Never Married 2 Married Maryland 21215-0036 White 1 ☐ Yes 2 No Specify: If Yes, Give Year or Dates 3 X Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry permit. Page 1 and 2 should be filed within 72 i.
Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "ne any injury or other traumatic event, the Machine. (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) 6 Homemaker Own Home Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) ပ Sadie Feltor John Weaver 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 120 Mountain Laurel Drive, Milton DE 19968 Earl Howard-son Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place)
Cedar Hill Cemetery 1 🕅 Burial 2 🗆 Cremation 3 🗀 Removal from State Apr. 18, 2011 Brooklyn Park Maryland 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Ambrose Funeral Home Inc. 21. Signature of Figeral Service Licensee 1328 Sulphur Spring Road Arbutus Maryland 21227 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Onset and Death Immediate Cause (Final Physician noumonia Medical resulting in death) Due to (or as a consequence of): Examiner Hemoror Sequentially list conditions, Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of): signed by the attending physician and defected for use as the burial-transit that initiated events Due to (or as a consequence of): resulting in death) Last Completed by Physician/Medical To the Hospital or Attending Physician: The law requires that the death certificate I within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physophopical princin by the funeral director, page 2 should be detached for use as the IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy
5 Other (specify) ____ in the past 12 months?

1 Yes 2 No Month Day Year Pregnant at time of death 4 ☐ Pregnant 9 ☐ Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown 24a. Was an Were autopsy findings available prior to completion of cause of autopsy perform death? 2 🗌 No Yes Yes Division of Vital Be (25. Was case referred to medical 26. Place of Death (Check only one) examiner Hospital 2-SINO Other: ၉ 1 Tes npatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred injury 1/SNatural 5 Pending 1 ☐ Yes 2 ☐ No ☐ Accident Investigation 6 Could not be 3 ☐ Suicide 4 ☐ Homicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) Medical 1-Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifie 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check Cartifying Nurse Practioner: To the best of my Impatedge, deat unity unity 29b. Signature and title of certifier 29c. License number 147 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 2 3455 Wilkers oskuran 31. Date filed (Month, Day, Year) State

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Decedent's Name (First, Middle, Last) 2 Date of Death 3. Time of Death Physician/ APRIL 1819 PM DRTIS OHNSO Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death **Examiner** Northwest Hospital Baltimore Randallstown If Under 1 Year | If Under 24 Hrs. Social Security Number 8. Date of Birth g. Birthplace (State or Foreign **Funeral** 7. Age (In yrs, last birthday) 1 X M 2 □ F Days Country) MD Director 215-74-9531 Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injuy or other traumatic event, the Medical Examiner must be notified at any injuy or other traumatic event, the Medical Examiner must be notified at 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location Director 1 Yes 2 ☐ No MD n/a Baltimore 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code Funeral USA 21215 3628 Fords Lane 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces?
1 ☐ Yes 2X No Completed by 1 X Never Married 2 Married 1 ☐ Yes If Yes, Give Baltimore, Maryland 21215-0036 Specify: African-American 1 ☐ Yes 2 X No Specify: 3 Divorced 4 Divorced Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Medstar Floor Tech Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Malden Surname) ပ Viola Flynn John C. Johnson 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 7073 McClean Blvd. Parkville, MD 21234 Michael Johnson/Son 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Date 1 N Burial 2 □ Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify) 4-22-2011 Lansdowne, Maryland Mt. Zion Cemetery 22. Name and Address of Facility Wie Funeral Time P.A. of Balto. Co. of Funeral Service Licenses Signature P 9200 Liberty Road, Randallstown, MD 21133 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock or heart failure. List only one cause on each line.

Immediate Cause (Final Approximate Interval Between Onset and Death Ph_sician/ ATHENOSCIENDTIC CARDIOVASCULAR disease or condition Medical resulting in death) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury that initiated events Examine Due to (or as a consequence of) To the Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-transit Due to (or as a consequence of): resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months? Month Day Year Pregnant at time of death 2 No cate has been signed by the a page 2 should be detached 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of 24a. Was an certificate has autopsy performe death? 1 ☐ Yes 2 🕡 1 ☐ Yes 2 ☐ No Be the funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) Hospital 2 No Other: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 욘 1 🗌 Yes 4 Nursing Home 5 Residence 6 Other (Specify) After this 28b. Time of 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28c. Injury at 28d. Describe how injury occurred Natural injury work? 1 ☐ Yes 2 ☐ No 5 Pending within 24 hours after death.

To the Funeral Director: A 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, completed filled in by determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifie (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one) 29b. Signature and 30. Name and address of person who completed of death (Item 23a) (Type, Print) MCGANN 5401 OLD COURT BUIN-SEAN 31. Date filed (Month, Day, Year) Registrar

DHMH 17 Rev 7/2009

DHMH 17 Rev 1/2001

State

Registrar

31. Date filed (Month, Day, Year)

APR 1 5 2011

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Amend Item State of Maryland / Department of Health and Mental Hygiene 2

Amend Item 3 per dr., g914,04/15/2011dhb

Certificate of Death

Reg. No. 3. Time of Death Unknown M 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month rayncei 201 Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death **Examiner** 4b. City, Town, or Location of Death Lanva Himore 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Months Hours Min (Month, Day, Ye Country) Director Usual Residence of Decedent 28a-f show permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f shown injury or other traumatic event, the Medical Examiner must be notified at once. 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Completed by Funeral Director Baltimore 1 Yes 2 ☐ No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21217 USA Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14 Race - American Indian Armed Forces?

1 Yes 2 No
If Yes, Give
Year or Dates. Black, White, etc. 1 Never Married 2 Married Maryland 21215-0036 1 Yes 2 No Specify Specify: Black 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15 Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) DisAbled DISAbled Be . Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Kane 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) *5*34 Kane, anvale St. Baltimore, MD David Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place, Date 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Baltimore, MD -13-2011 21. Signature of Funeral Service Licensee March 1101 E. North Ave 22. Name and Address of Picility Baltimore, MO 21202 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line. Immediate Cause (Final Infarction Physician/ yocardia disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions, Lary, leading to inmediate cause. Enter Underlying Cause injury Due to (or as a consequence of) To the Hospital or Attending Physician: The law requires that the death certificate be executed use as the burial-transi attending physician and that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery Ectopic pregnancy in the past 12 months?

1 Yes 2 No Day Month 5 Other (specify) Pregnant at time of death ☐ Pregnam the a 9 Unknown cate has been signed by page 2 should be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Completed 1 🗌 Yes 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has autopsy 1 ☐ Yes 2 ☐ No Yes director, Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home SX Residence 6 Other (Specify) 2 X No Hospital: မ 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA After this 28a. Date of injury (Month, Day, Year) Certificate: 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred Natural work? 1 ☐ Yes 2 ☐ No injury 5 Pending Accident Investigation Within 24 hours after deat To the Funeral Director: Suicide 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Homicide determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) K. G. Schuder D39758 2011 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

**Rev:n Schendel MD 16 EU+aw Frenkic Kevin Schendel MD

DHMH 17 Rev 7/2009

State Registrar 31. Date filed (Month,

APR 1 5 2011

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Reg. No. Certificate of Death Registrar 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) April Physician/ 6:40 Kimball Aurea Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (if not institution, give street and number) **Examiner** Baltimore Maria Health Care Center Baltimore 9. Birthplace (State or Foreign Country) Maryland If Under 8. Date of Birth 1 Year If Under 24 Hrs 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Days Jan. 19, 1929 Months Hours 1 □ M 2 🛛 F 82 220-62-3187 Director Usual Residence of Decedent er than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at 10d. Inside City Limits 10c. City, Town or Location 10b. County 10a, State Director 1 Yes 2 V No Baltimore Maryland Baltimore 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number Funeral 21212 U.S.A. 6401 N. Charles Street Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) death v 14. Race - American Indian, 12. Was Decedent Ever in U.S. 11 Marital Status Black, White, etc. Armed Forces 1 X Never Married 2 Married 1 ☐ Yes 2 🌠 No If Yes, Give δ within 72 hours after Maryland 21215-0036 1 ☐ Yes 2 X No Specify: White 3 Widowed 4 Divorced Completed Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) should be filed within 72 h and Mental Hygiene. 7 is marked other than "r College (1-4 or 5+) 5+ years Elementary/Seconday (0-12) Teacher Education Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Stehle John Arthur Kimball Louise Agnes 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) permit. Page 1 and 2 sh Department of Health ar Important: If item 27 is any injury or other trau 6401 N. Charles Street Baltimore, Maryland 21212 Sr. Bernice Feilinger, S.S.N.D. Baltimore, 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 1 N Burial 2 Cremation 3 Removal from State 4-19-11 Glen Arm, Maryland 4 Donation 5 Other (Specify) Villa Maria Cemetery 21. Signature of Funeral Service Licensee itchell-Wiedefeld Funeral Home, Inc. 6500 York Road Baltimore, Maryland 21212 Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Betweer Onset and Death Immediate Cause (Final week Pryrician/ disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner Sequentiany list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury Due to or as a consequence of) burial-transi that initiated events Due to (or as a consequence of) resulting in death) Last attending physician Physician/Medical or Attending Physician; The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 use as the IF FEMALE: ves, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant Live Birth 2 - Fetal death Ectopic pregnancy 3 ☐ Ectopic pregna 5 ☐ Other (specify) in the past 12 months? Vear Month Day ō Pregnant at time of death signed by the a Id be detached fo Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown been si Be Completed 24b. Were autopsy findings available prior to completion of cause of 24a Was an autopsy performed? Yes 2 No this certificate has page 2 death? 1 ☐ Yes 2 ☐ No ensess 25, Was ca eferred to medical examine 2 director, 26. Place of Death (Check only one) Other: 1 ☐ Yes 2 No ျှ 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA funeral of 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury at Certificate: within 24 hours after death.

To the Funeral Director: After completed filled in by the funer 5 Pending Natural 1 Yes 2 No Accident Investigation 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide 4 ☐ Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined To the Hospital Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 3 only 29d. Date signed (Month, Day, Year) 29b, Signature and title of certifie 2011 56623 e and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar

TDHMH 17 Rev 7/2009

State

31. Date filed (Month, Day, Year)

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death . 2011 Month Physician/ John baci Homs 8:35 PM April 13 Medical 4a. Facility Name (if not institution, give street and number, 4c. County of Death Examiner 4b. City, Town, or Location of Death Baltimore 1205 Shore Road Middle River 9. Birthplace (State or Foreign Country) Iowa . Age (In vrs. last birthday 8. Date of Birth **Funeral** 1 X M 2 □ F Min. Months Hours (Month, Day, Year) **Director** 478-36-0456 76 Usual Residence of Decedent or 28a-f show notified at 10d. Inside City Limits 10b. County 10c. City, Town or Location filed within 72 hours after death with the Maryland Director 1 Yes 2 X No Maryland Baltimore Middle River 10f. Zip Code 10g, Citizen of What Country? 10e. Street and Number ò "natural", or items 23a o Funeral 1205 Shore Road 21220 S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces?

1 X Yes 2 No
If Yes, Give Black, White, etc. 1 Never Married 2 X Married þ 1954 Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify: 3 Divorced 4 Divorced 1957 Completed White Year or Dates er than "natur , the Medical I 15 Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Electrical Engineer Aero Space is marked other traumatic event, Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) and Mental 2 Page 1 and 2 should be a ment of Health and Menta Frances Margaret Fearneyhough Earl Roscoe Korns 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 27 permit. Page 1 and 2 Department of Health Important: If item 27 any injury or other tr once. Middle River, Maryland 21220 Ann Korns (Wife) 1205 Shore Road 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 1 Burial 2 X Cremation 3 Removal from State Baltimore, Maryland 4 Donation 5 Other (Specify) Bayview Crematory 4/14/2011 21 Signature of Leneral Service (i.e. ^{22. Name and Address of Facility} Bruzdzinski Funeral Home PA 1407 Old Eastern Avenue Es Vielaro Maryland 21221 a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause or each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition Physician/ Month Metastatic Lung Cancer Medical resulting in death) Due to (or as a consequence of Examiner Hypertension Years Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of) Cause (Disease or linjury that initiated events resulting in death) Last burial-transit The law requires that the death certificate be executed Years <u>Osteoporosis</u> Due to (or as a consequence of): physician the burial Physician/Medical Division of Vital Records, P.O. Box 68760 attending p for use as t IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) in the past 12 months? Year Month Day Pregnant at time of death been signed by the should be detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 XYes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a, Was an page 2 s performed 2 🗌 No 1 Tyes To the Hospital or Attending Physician: burs after death.

eral Director: After this certific filled in by the funeral director, 25. Was case referred to medical To Be 26. Place of Death (Check only one) Other: 4 \(\text{Nursing Home} \) 5 \(\text{Residence} \) 6 \(\text{Other (Specify)} \) 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at Certificate: Natural 5 Pending 1 Yes 2 No 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined within 24 hours a

To the Funeral C Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier Salsa Siddigi 04/496 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Dr. Saba Siddigi M.D. 9106 Philadelphia Road Suite 205 Rosedale, Maryland 21237 31. Date filed (Month; Day, Year) State

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Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No 1. Decedent's Name (First, Middle, Last) 2. Date of Death KOTOWSKI Physician/ 2019 APRIL MARTE DORIS 3:20 A.M Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death FRANKLIN WOODS CENTER BALTIMORE ROSEDALE 9. Birthplace (State or Foreign Social Security Number 6. Sex If Under 1 Year If Under 24 Hrs, 8. Date of Birth Funeral 7. Age (In vrs. last birthday) 1 DM 2 F Days Hours Mir MARYT. **Director** Yrs 215-14-7610 89 Usual Residence of Decedent show 10a. State 10b County with the Maryland notified at 10c. City, Town or Location 10d. Inside City Limits Director 28a-f 1 Yes 2 XNo MD BALTIMORE GLENMONT 10e Street and Number ō 10f. Zip Code 10g. Citizen of What Country? Examiner must be Funeral items 23a 6920 DONACHIE ROAD APT. 1102 21239 USA 72 hours after death 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian Black, White, etc. ō þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 Yes 2 Ty No If Yes, Give Year or Dates 1 ☐ Yes 2 🕱 No Specify: "natural", Specify: Completed 3 XWidowed 4 Divorced WHITE the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working and Mental Hygiene. is marked other than life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) CLERK 12TH GRADE STATE OF MARYLAND Be permit. Page 1 and 2 should be filed v Department of Health and Mental Hyg Important: If item 27 is marked oth any injury or other traumatic event, 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ JOHN A. GRAY EMMA B: AXT 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) CLARENCE M. YOUNG, JR./FRIEND 6920 DONACHIE RD. APT. 1002 BALTIMORE, 21239 MD 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date 1 🔀 Burial 2 🗆 Cremation 3 🗆 Removal from State cemetery, crematory or other place, LORRAINE PARK 4/16/2011 4 Donation 5 Other (Specify) WOODLAWN, MD MO1139 22. Name and Address of Facility 21. Signatury of Funeral Sellvice Lig THE JOHNSON FUNERAL HOME, P.A. 8521 LOCH RAVEN BLVD. TOWSON, MD and 1. Enter the disease, or complections that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Physician/ disease or condition neuwoni Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, Examine if they leading to immedit cause. Enter Underlying Cause (Disease or iinjury Hospital or Attending Physician: The law requires that the death certificate be executed burial-transi that initiated events resulting in death) Last and Due to (or as a consequence of): attending physiciar Physician/Medical Division of Vital Records, P.O. Box 68760 the use as IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No for Month Year Other (specify) Dav Pregnant at time of death 4 ☐ Pregnant : 9 ☐ Unknown signed by the a Unknov Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Completed should been 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an certificate has autopsy page 2 1 Yes 2 No 25. Was case referred to medical examiner?
1 ☐ Yes 2 ☐ No filled in by the funeral director, 26. Place of Death (Check only one) Be Other: မ 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Nursing Home 5 Residence 6 Other (Specify After this 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred iniury Natural 5 Pending work? 1 ☐ Yes 2 ☐ No death. Investigation Accident 24 hours after deat Funeral Director: Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 - Homicide determined City or Town, State) Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. completed Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check within 2 To the I only one) 29b. Signature and titl 29c. License number 29d. Date signed (Month, Day, Year) w

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State Registrar 30. Name and addre

31. Date filed (Mohth

2106

of person who completed cause of death (Item 23a) (Type, Print)

OAKWOOD

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiener 1 - For State Registrar Certificate of Death Reg. No. Decedent's Name (First, Middle, Last) 2 Date of Death 3. Time of Death Physician/ OLIVIA Month Loria Lunn 61,20A M APTIL 201 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death more If Unde If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) **Funeral** Months Days 1 M 2 F Min. Month, Day, Yrs Director June 13 Usual Residence of Decedent 10a. State 10b. County the Maryland ms 23a or 28a-f shormust be notified at 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 No mor 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral with 1 items Page 1 and 2 should be filed within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian Examiner Black. White, etc. ō þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 No Specify: "natural", Completed 3 Widowed 4 Divorced B the Medical 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) than Elementary/Seconday (0-12) I Hygiene. College (1-4 or 5+) Grovern ment event, Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Department of Health and Mental I Important: If item 27 is marked o any injury or other traumatic eve ၉ 19a. Informant's Name/Relationship (Type, Print) (ຣັດດັ່) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 78 Burnie MD enwood 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date 1 Burial 2 Cremation 3 Removal from State cemetery, crematory or other 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service 16 Name and Address of Facility Home, Part 1. Enter the disease shock, or heart failure. Lis complications that caused only one cause on each line Approximate Interval Between Onset and Death he death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Immediate Cause (Final cancer Physician/ DUN disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, isaling to immediate cause. Enter Underlying Examine Due to (or as a consequence of). attending physician and for use as the burial-transit Cause (Disease or iinjury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical b Hospital or Attending Physician: The law requires that the death certificate be a 24 hours after death.
Property of the action of the action of the action of the attending physicial process. P.O. Box 68760 IF FEMALE: yes, outcome of pregnancy

Live Birth 2 Fetal death

Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Month Dav Year 5 Other (specify) been signed by the a should be detached t 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ Division of Vital Records, 2 No 3 ☐ Probably 4 ☐ Unknown 1 Yes cate has been si Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a Was an autopsy performed Yes 2 25. Was case referred to medica completed filled in by the funeral director, Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 1 No ည 1 🗆 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred Natural 5 Pending injury work? 1 ☐ Yes 2 ☐ No Accident Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 29a. Certifier 1 🗹 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check within 2 only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 4/8/11 DOUS7465 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
W.S. KYRPAKICMO 2575 Smith N S-W. Baltomore, MD. NS KYAPAKIEMO 5-203

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State

Registrar

31. Date filed (Month, Day, Year)

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Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend item 1 per doc g914 4-15-11 vt
State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. Sam Lewis AKA Sam Lifshitz 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Month **Physician** Appi 2011 /Medical Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Kundylk town brzten Baltimore 05DI tal If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 10/31/1920 5. Social Security Number 7. Age (In yrs. last birthday, Birthplace (State or Foreign Country) **Funeral** Hours Days Months 1 X M 2 □ F NY 130-10-7702 90 Director Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene. Int If item 27 is marked other than "natural", or items 23a or 28a-f show 10d. Inside City Limits 10a. State 10h County 10c. City, Town or Location "natural", or items 23a or 28a-f show dical Exarct rust be notified at 1 ☐ Yes 2 X No Director MD BALTIMORE OWINGS MILLS 10g. Citizen of What Country? 10e. Street and Number 10f. Zin Code 4730 ATRIUM COURT, Funeral #424 21117 USA 12. Was Decedent Ever in U.S. Armed Forces?
1 Payes 2 No If Yes, Give Year or Dates: 14. Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐Yes 2 No Specify: Specify: <u>۾</u> 3 Widowed 4 Divorced WHITE or than "natura Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 27 is marked other than "r. r traumatic event Elementary/Secondary (0-12) College (1-4or 5+) WHOLESALE HARDWARE COMPTROLLER 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be LEVY LOUIS LIFSHITZ MARY ೨ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and Department of Health Important: If item 27 any Injury or other troonce. 4730 ATRIUM COURT, #424, OWINGS MILLS, MD 21117 MURIEL LEWIS / WIFE 20c. Location - City or Town, State 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 1 X Burial 2 ☐ Cremation 3 X Removal from State 4 ☐ Donation 5 ☐ Other (Specify) BETH DAVID CEMETERY 04/14/2011 ELMONT, NY 21. Signature of Funeral Service Licer 22. Name and Address of Facility SOL LEVINSON & BROS., INC. 8900 REISTERSTOWN ROAD, PIKESVILLE, MD 21208 Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Cardiaxascular Physician Atheroscleroti /Medical Due to (or as a consequence of): Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or at a consequence of) Hospital or Attending Physician: The law requires that the death certificate be executed Exami burial-trar Due to (or as a consequence of): attending physician for use as the buria Division of Vital Records, P.O. Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day in the past 12 months? 1 ☐ Yes 2 ☐ No 4 ☐ Pregnant at time of death 5 Other (specify) certificate has been signed by the irector, page 2 should be detached 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. δ 4 Unknown 1 ☐ Yes 2 ☐ No 3 ☐ Probably Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 1 No 1 ☐Yes 2 ☐No 1 🗆 Yes Be 25. Was case referred to medica examiner? 26. Place of Death (Check only one) funeral director, Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No Hospital: 1 ☐ Yes 1 🔲 Inpatient ER/Outpatient 3 DOA Certification: To After this 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 2 ☐ Accident 5 Pending investigation n 24 hours after death.

e Funeral Director: Af 1 ☐ Yes 2 ☐ No 6 ☐ Could not be 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical 29a. Certifier within 24 ho

To the Fune

completely f (Check only one) and manner stated. 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifie April 13, 2011 140055644 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 5401 OH COURT Rd Randallstown MD 2113 YORKE DU Northwest Hospital mitee 31. Date filed (Month, Day, Year) State 1 APR 5 Registrar

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month April 1002 AM Frank Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** 6. Sex 1 XM 2 □ F 7. Age (In yrs. last birthday) If Under 1 Year I If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign Social Security Number **Funeral** Months Days Hours Min. 6-3-1936 Country) 216-32-2012 MD **Director** Usual Residence of Decedent 28a-f show 10b. County 10d. Inside City Limits permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at 10a. State 10c. City, Town or Location Director 1 Yes 2 XNo Randallstown MD Baltimore 10e, Street and Numbe 10f. Zip Code 10g. Citizen of What Country? Funeral 9708 Fustice Road 21133 USA Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian. 11. Marital Status Black, White, etc. ģ 1 Never Married 2 XMarried 1 ☐ Yes 2 ☐ No If Yes, Give X Year or Dates. Baltimore, Maryland 21215-0036 African-American 1 ☐ Yes 2 X No Specify: Completed 3 Widowed 4 Divorced 15. Decedent's Education 16a. Decedent's Usual Occupation 16h Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life, DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Bethlehem Steel Steel Coordinator 12th Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 Doris Brown Frank Merchant Sr. 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 9708 Fustice Road, Randallstown, MD 21133 Whynolia Merchant/Wife 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Date 1 X Burial 2 Cremation 3 Removal from State Woodlawn Cemetery 4-12-2011 Woodlawn, MD Donation 5 Other (Specify) 22. Name and Address of Facility Wile Funeral Home F.A. of Balto. Co. 21. Sign rure of Funeral Service Licens 9200 Liberty Road, Randallstown, MD 23a. Far 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final CARDIDVASCULAR Physician/ ARTHUVSC disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Securitielly list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of) To the Hospital or Attending Physician: The law requires that the dea h certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): the a ending physician a hed for use as the burial-Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy
5 Other (specify) in the past 12 months?
1 Yes 2 No Month Vear Day Pregnant at time of death signed by the a 9 Unknown Linknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 2 No 3 Probably 4 Unknown peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 s autopsy perform 2 🗆 No this certificate 2 SNO Yes 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? 2-No 1 🗌 Yes 1 Inpatient 2 R/Outpatient 3 DOA ျ 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred eral Director; After filled in by the funer Natural Accident iniury work? 1 ☐ Yes 2 ☐ No 5 Pending Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, Homicide determined City or Town, State) within 24 hours a To the Funeral I Medical 1 🗡 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

State

DHMH 17 Rev 7/2009

Registrar

29b. Signature and title of certific

31. Date filed (Month, Day, Year)

CL) FFTRD

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

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32. Registrar's Signature

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RANDAL

STOWN MARYLAND

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3 Time of Death Physician/ $04 - 10 - 2011^{\text{Day}}$ James A. McGarrity 331 A Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death 827 Sidehill Drive Bel Air Harford If Under 1 Year If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Days 1 X M 2 □ F Months Hours Min. 01-24-1943 Country) 68 Director 216-42-0061 MD Usual Residence of Decedent of other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at 10a. State filed within 72 hours after death with the Maryland 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 No Harford Bel Air 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 827 Sidehill Drive 21015 USA 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 A No Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. 1 Never Married 2 X Married Completed by 1 Yes Baltimore, Maryland 21215-0036 1 Yes 2 X No Specify: Specify: White 3 Widowed 4 Divorced Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15 Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) General Contractor Construction Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည James S. McGarrity Stella M. Lonczyski 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mahla A. McGarrity (wife) 827 Sidehill Drive Bel Air, MD 21015 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 X Burial 2 Cremation 3 Removal from State BelAir Mem. Gardens | 04-13-2011 Bel Air, MD 4 Donation 5 Other (Specify) 22. Name and Address of Facility Schimunek Funeral Home of BelAir Inc 610 W. MacPhail RD Bel Air, MD 21014 Signature of Funeral Service Licensee 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition Physician/ Parluns end sta Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Examiner Due to (or as a consequence of): The law requires that the death certificate be executed Due to (or as a consequence of): resulting in death) Last the burial attending physician Completed by Physician/Medical for use as 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 3 Ectopic pregnancy

5 Other (specify) IF FEMALE: 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months? Day 1 Yes 2 No g 🗌 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? arthur 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an was ...
autopsy
performed?
Yes 2 N page 2 certificate 2 No 1 Yes Hospital or Attending Physician: completed filled in by the funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) To Be examiner? Other: 1 Tes 2 No 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: 1 Natural 2 Accident 5 Pending s after death. 1 Yes 2 No Investigation 3 Suicide 4 Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) 24 hours a Funeral C Medical 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. To the 1 within 2 To the 1 29b. Signature and title of certifie 29c. License numbe 29d. Date signed (Month, Day, Year) David 5 032270

104 State

Box 68760

P.O.

Records,

of Vital

Division

Registrar DHMH 17 Rev 7/2009 CITW. MA-PhA

32. Redistrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

12000

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APR 15

31. Date filed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene for State Registrar Reg. No. Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ 50 George Moore Month Year Samuel 10:25 AM Medical Facility Name (if not institution, give street and number) **Examiner** Baltimore Randallstown Jeasons Hospice 8. Date of Birth
Month, Dat (ear) Social Security Number 7. Age (In yrs. last birthday) Yrs. 1 Year If Under 24 Hrs. If Under **Funeral** 9. Birthplace (State or Foreign Months **Director** Usual Residence of Decedent 28a-f shov permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f shown injury or other traumatic event, the Medical Examiner must be notified at once. 10b. County 10a. State 10c. City, Town or Location 10d. Inside City Limits Director timore MD 1 Yes 2 No 10e. Street and Number 10g. Citizen of What Country? Funeral USA 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Forces?

1 X Yes 2 No
If Yes, Give
Year or Dates. þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 Tes 2 No Specify. Completed 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry College (1-4 or 5+) Be 7. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 01 bore 19b. Mailing Address (Street and Number or Rural Route Number, 300 N. lonastery Place of Disposition (Name of Method of Disposition Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) ure of Funeral Service License 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Renal Carcinoma Physician disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examiner Due to (or as a consequence of): the burial-transi Cause (Disease or imjury that initiated events Due to (or as a consequence of): resulting in death) Last attending physician Physician/Medical or Attending Physician: The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 IF FEMALE: nse 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ctopic pregnancy
5 Other (specify) in the past 12 months?

1 Yes 2 No Dav Pregnant at time of death Unknown the page 2 should be detached 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Completed 2 No 3 ☐ Probably 4 ☐ Unknown 1 Yes 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? autopsy certificate 1 Yes 2 No Yes director, 25. Was case referred to medical Be 26. Place of Death (Check only one) ê. 6 Dother (Specific) + n espice 2 1 No Other: 1 🗌 Yes 1 Inpatient 2 I ER/Outpatient 3 I DOA 4 Nursing Home 5 Residence After this filled in by the funeral 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate; 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 🗹 Natural work? 5 Pending within 24 hours after death.

To the Funeral Director: A 2 Accident
3 Suicide
4 Homicide 2 🗌 No Investigation Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) To the Hospital Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifier completed Medical Examiner: On the basis of examination and/or investigation, in this opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 3 29b. Signature and title of certifier SRAUPENSE M.D 29d. Date signed (Month, Day, Year) P0057465 4/13/11 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

N S Ray Apa KSL / M D 2835 Sm I M Baltimore, MD. 21709 5-203 31. Date filed (Month, Day, Year) State varke

DHMH 17 Rev 7/2009

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** Michael C. Merz, Sr. 12:30 PM /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Baltimore Franklin Kosedale 8. Date of Birth (Month, Day, Year) Oct. 31, 1959 Social Security Number If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign . Age (In yrs. last birthday) **Funeral** Days Hours 1**∑**M 2□ F Months 215-84-8516 Baltimore, MD 51 **Director** Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits f show ortant: if item 27 is marked other than "natural", or items 23a or 28a-f sho Injury or other traumatic event, the Woolgal Examiner must be notified at MD Baltimore Director Parkville 1 ☐ Yes 2X No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 9636 Alda Drive 21234 United States Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ▼ Yes 2 □ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Bace - American Indian. 11. Marital Status Black, White, etc. 1 Never Married 2 Married $\mathbb{M} \in \mathbb{Z}$, $\mathbb{M} \cap \mathbb{Z} \in \mathbb{Z}$ Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No à Specify: White Specify: 3 ☐ Widowed 4 K Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Maryland Transportation Elementary/Secondary (0-12) College (1-4or 5+) Electronic Technician Authority 12 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) and 2 should be lealth and Mental John Martin Merz, Sr. Eleanor Stella Jakubowski 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 sh Department of Health and Important: If Item 27 is m any Injury or other traum 1409 Tayside Way, Bel Air, Maryland 21015 Donna Merrill/ Ex-Wife 20a. Method of Disposition 20b. Place of Disposition (Name of April 15, 20c. Location - City or Town, State Evans Funeral Chapel - Bel Ar 1 ☐ Burial 2 🛛 Cremation 3 ☐ Removal from State Forest Hill, MD 4 Donation 5 ☐ Other (Specify) Chapel-2011 21. Signature of Funeral Service Licenses 22. Name and Address of Facility
Evans aneral Chapel & Cremation Services 8300 Harford Rd. Parkville, MD 21234 2 a. P.Irt1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, nock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** /Medical resulting in death) Due to (or as a consequence of): Examiner Bacterial Peritonitis 20nTaneous Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examiner Due to (or as a consequence of) The law requires that the death certificate be executed physician and the burial-transi irrhosis that initiated events resulting in death) Last Due to (or as a consequence of) Box 68760 Physician/Medical ast the attending IF FEMALE: use yes, outcome of pregnancy
☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant in the past 12 months? 23d. Date of delivery 3 Ectopic pregnancy for Day Month Year 4 ☐ Pregnant at time of death 9 ☐ Unknown 5 Other (specify) signed by the a Ö 1 ☐ Yes 2 ☐ No 9 Hinknown ۵. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown Completed peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has e 2 s autopsy performed 1 Yes 2 No certificate 1 ☐ Yes 2 🗆 No the Hospital or Attending Physician: director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To this s after death.

I Director: After this
of in by the funeral d 27. Manher of Death Date of Injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? 5 Pending investigation 1 Naturai 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours aff

To the Funeral Di

completely filled in 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) within 2 To the I and manner stated. 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month, Day, Year) 30. Name and address of per npleted cause of dea th (Item 23a) (Type, Print) Baltimore, MD Franklin Kam Drive 31. Date filed (Month gistrar's Signature State Year!

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day 2011 Physician/ APRIL 4:21 P M HENRY THOMAS MARKOWSKI 13 Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death UPPER CHESAPEAKE MEDICAL CENTER BEL AIR **HARFORD** Social Security Number Sex 1 M 2 D F If Under 1 Year If Under 24 Hrs. **Funeral** 7. Age (In yrs. last birthday 8. Date of Birth 9. Birthplace (State or Foreign Hours July 15, 1932 Maryland 78 **Director** 218-28-8562 Usual Residence of Decedent show permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho any injury or other traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location Director 1 ☐ Yes 2 X No Maryland Harford Forest Hill 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 2006 Mardic Drive 21050 USA 12. Was Decedent Ever in U.S. Armed Forces? ↑E Yes 2 □ No If Yes, Give 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. ð 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 Yes 2 No Specify. 3X Widowed 4 □ Divorced Specify: White Completed Year or Dates Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Stevedore Freight Company 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Adolph (nmn) Markowski Stella (nmn) Turowski 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) ARLOWSKI John P. Markowski Sr. / Son 4022 East Baker Ave., Abingdon, MD 21009 20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Char (Specific) 20b. Place of Disposition (Name of cemetery, crematory or other place, 20c. Location - City or Town, State Highview Memorial Gdn 4-16-11 Fallston, Maryland 21. Signature of Fundal Service Licensee 22. Name and Address of Facility McComas Funeral Home, P.A. m 1317 Cokesbury Road, Abingdon, Maryland 21009 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line Immediate Cause (Final Onset and Death Ph_sician/ Res piratem disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Secrentially list conditions Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Hospital or Attending Physician: The law requires that the death certificate be executed for use as the burial-transi that initiated events Due to (or as a consequence of) resulting in death) Last s been signed by the attending physician should be detached for use as the burial Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No 5 Other (specify) Month Day Year Pregnant at time of death 9 Unknown 9 Unknown Records, P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Be Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a. Was an certificate has page 2 autopsy perform 25. Was case referred to medical examiner? Vital completed filled in by the funeral director, 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No မ 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA After this 28a. Date of injury (Month, Day, Year) Division of 27. Manner of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 5 Pending 1 Natural 1 Yes 2 No Accident Investigation within 24 hours after deal To the Funeral Director; 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 1. 🔀 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Defitying Prijaction in the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated a Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifiq D0068014 500, upper chesapeane 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Air MD 21014 31. Date filed (Month, Day, Year APR 1 5 32. Registrar's Signature State 5 201 Registrar

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene? State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death AMonth Physician/ 10 32 PM 201 Medical 4a. Fecility Name (if not institution, give street and number, 4c. County of Death **Examiner** Town, or Location of Death of Baltimore in TIMORE If Under 1 Year 8 Date of Birth Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** 1 🗆 M 2 🔽 Months th, Day, Director items 23a or 28a-f show 10b. County 10c. City, Town or Location 10d. Inside City Limits injury or other traumatic event, the Medical Examiner must be notified at Director 1 Yes 2 No MOB 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? Completed by Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Was Decedent Ever in U.S. 14. Race - American Indian. Armed Forces?
1 ☐ Yes 2 ☐ No Black, White, etc. 6 1 Never Married 2 Married permit. Page 1 and 2 should be filed within 72 hours after of Department of Health and Mental Hygiene. 1 Yes If Yes, Give 1 Yes 2 No Specify 3 ₩idowed 4 Divorced marked other than "natural" Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Department of Health and Mental Hygiene. Important: If item 27 is marked other tha Be 17. Father's Name (First, Middle, Last 18. Mother's Name (First, Middle, Maiden Surname) ည 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number Rural Route Number, City or Town, State, Zip Code) MORGAN Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 1 Burlal 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) 21. Signature of Funeral Service Licenses 21224 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line, Immediate Cause (Final Physician/ Due to (or as a consequence of): disease or condition resulting in death) ATHERO co disverbles directs Medical **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Examiner Due to (or as a consequence of) To the Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-tran that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death
9 Unknown 23b. Was decedent pregnant in the past 12 months?
1 ☐ Yes 2 ☐ YNo
9 ☐ Unknown 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ Month n signed by the a Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e, Did tobacco use contribute to the cause of death? þ 2 No 3 Probably 4 Nonknown Completed by the tuneral director, page 2 should certificate has been 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy performed' death? 1 Yes 1 Yes 2 No Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No ျပ 1 ☐ Inpatient 2 ☑ ER/Outpatient 3 ☐ DOA After this 28a. Date of injury (Month, Day, Year) 28c. Injury at work?
1 ☐ Yes 2 ☐ No Certificate: 27. Manner of Death 28b, Time of 28d. Describe how injury occurred Natural 5 \square Pending ☐ Accident ☐ Suicide Investigation 24 hours a er deat Funeral Director: 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, ☐ Homicide City or Town, State within 24 hours a

To the Funeral Di

completed filled Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. only one Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier 2011 0059056 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 13-1+ MD 6821 reisturation R2 31. Date filed (Month. R 15 Registrar's Signature State Registrar

DHMH 17 Nev 7/2006

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** 2011 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner The Johns Hopkins Hospital N/A Baltimore City 8. Date of Birth (Month, Day, Year) If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1 X M 2 - F Yrs. Director 213-78-1011 49 Jul 8, 1961 Maryland Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene.

ant: If item 27 is marked other than "natural", or items 23a or 28a-f show ury or other traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1X Yes 2 No Baltimore Maryland Baltimore 10e. Street and Number 10f. Zip-Code 10g. Citizen of What Country? 1217 63rd Street 21237 U.S.A. Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married Yes 2 No 1 ☐ Yes 2 🙀 No Specify: þ Specify. 3 Widowed 4 Divorced Black Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) Self Employed Hair Stylist 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Earl S. Moore Mary Martin မ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1217 63rd Street Baltimore, Maryland 21237 Mary Martin 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 ☐ Burial 2 ☑ Cremation 3 ☐ Removal from State permit. Page Department o Important: If any injury or once, 04/13/11 4 Donation 5 Other (Specify) Baltimore, Maryland On Site Cremation 21. Sign of Europa Service Licenses 22. Name and Address of Facility Estep Brothers Funeral Service, P. A. 1300 Eutaw Place Baltimore, Md 2121
Do not enter the mode of dying, such as cardiac or respiratory arrest, Enter the disease, or complications that caused the death. Approximate Interval Between Onset and Death shock failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examiner Due to (of as a consequence on) resulting in death) Last Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery Live birth 2 - Fetal death 3 Ectopic pregnancy in the past 12 months? Month Day Year 4 Pregnant at time of death 9 Unknown 5 Other (specify) 2 No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? þ 1 Tes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed Be မ Certification:

Division of Vital Records, P.O. Box 68760,

Baltimore, Maryland 21215-0036

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours effect death.

To the Funeral Director. After this certificate has been signed by the attending physician and completely filled in by the Attunest director, page 2 should be detached for use as the burnal-transit completely filled in by the Attunest director, page 2 should be detached for use as the burnal-transit

							1	1 🗌 Yes	2 No	1 🗌 Yes	2 🗌 No		
25.	25. Was case referred to medical		26. Place of Death (Check only one)										
	examiner?	No	Hospital: 1 Inpatient 2	idence 6	Other (Spec	cify)							
27.	Manner of Deat		28a. Date of Injury	28b. Time of	28c	. Injury at	28d. [Describe	how injury	occurred			
	1 Natural 2 Accident	5 Pending investigation	(Month, Day Year)	l Injury M		Work? 1 ☐ Yes 2 ☐ No							
	3 ☐ Suicide 4 ☐ Homicide	6 Could not be determined	28e. Place of injury - At ho building, etc. (Specify		ctory, of	ffice	28f. Location (Street and Number or Rural Route City or Town, State)			ıral Route Number,			
298	a. Certifier (check only	1 Certifying Phy Medical Exam	ysician: To the best of my kno niner: On the basis of examina	wledge, death occu	rred at	the time, date and pla my opinion, death o	ace, and d ccurred at	lue to the	e cause(s) a	and manner as	stated. e to the cause(s)		

29b. Signature and title of certifier

April 6, 2011

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

and manner stated

Raymond

600 North Wolfe St, Baltimore, MD, 21287

State

Medical

Registrar

one)

31. Date filed (Month, Day, Year) 32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. The Per Phy &FH C914 4/21/2011 JH State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ 11, 2011 ear APRIL **EVELYN** p^{M} MACKLEY Evelyn M. 2:30 Mackley Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death 412 S. EAST AVENUE N/A BALTIMORE 5. Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** 8. Date of Birth Months Days Hours Min OCT. 30 1 M 2 X ^{ar)}1929 Director 2.17-2.6-1998 81 MARYLAND Usual Residence of Decedent 23a or 28a-f show 10a, State 10b. County with the Maryland Director Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits MD N/ABALTIMORE 1 X Yes 2 ☐ No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 412 S. EAST AVENUE 21224 U.S.A. or items within 72 hours after death 12. Was Decedent Ever in U.S. 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Forces?

1 Yes 2 No If Yes, Give 1 Never Married 2 Married þ Maryland 21215-0036 1 Tes 2 XNo Specify: "natural", Specify: 3 XWidowed 4 Divorced Completed WHITE Year or Dates the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Page 1 and 2 should be filed within 72 ment of Health and Mental Hygiene. ant: If item 27 is marked other than ' ury or other traumatic event, the Me Elementary/Seconday (0-12) College (1-4 or 5+) HOUSEWIFE DOMESTIC Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Laden Survarie)

Josephine, Szatkowski WITOLD BOROWSKI 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) RAY WASSMAN/ SON EAST AVENUE, BALTIMORE, MD 412 21224 permit. Page 1 and 2 Department of Healt Important: If item 2 any injury or other Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place 1 Burial 2 X Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) BAYVIEW CREMATORY 4/13/11 BALTIMORE, MARYLAND 21. Signature of Fund Name and Address of Facility
LLLY & ZEILER INC. FUNERAL HOME
00 S. CONKLING STREET, BALTO., MD rvice Licensee ŗĽ<u>š.</u> 21224 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Physician/ SCV disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, in any, leading to infinediate cause. Enter Underlying Physician/Medical Examiner Dub to (or as a consequence or): COPD Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or iinjury that initiated events been signed by the attending physician and should be detached for use as the burial-trar Due to (or as a consequence of): resulting in death) Last Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No
9 Unknown Month Day Year 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Completed 1 Yes 2 No 3 Probably 4 Unknown page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an within 24 hours after death.

To the Funeral Director, After this certificate has performed? Yes 2 No 1 Yes 2 No æ 25. Was case referred to medical 26. Place of Death (Check only one) 1 ☐ Yes 2 X No Hospital: Other: 잍 4 ☐ Nursing Home 5 Residence 6 ☐ Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred 1X Natural 5 Pending 2 Accident
3 Suicide
4 Homicide 1 Yes 2 No Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifier 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b, Signature and title of certifie 29c. License number 29d. Date signed (Month, Day, Year) D002 1300 04/13 71 NG) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) iÔ√ 3 700 100 31. Date filed (Month, Day, Year) State Registra

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death I. Decedent's Name (First, Middle, Last) 2. Date of Death Month (Physician/ MOORE SELESTA н. Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** BALTIMORE GOOD SAMARITAN HOSPITAL 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth Birthplace (State or Foreign Country) **Funeral** 1 🗆 M 2 🗶 F Hours Min. Months MARCH 9, Director 218-26-6736 80 Usual Residence of Decedent or 28a-f show notified at 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County the Maryland Director 1 X Yes 2 No BALTIMORE MD 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ō "natural", or items 23a o Funeral with 1 21234 USA 2430 BRIDGEHAMPTON DR. APT. C 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11 Marital Status Black, White, etc. þ 1 Never Married 2 Married Yes 2 XNo 1 ☐ Yes 2 X No Specify. If Yes, Give 3 Widowed 4 Divorced Completed BLACK Year or Dates. permit. Page 1 and 2 should be filed within 72 hour Department of Health and Mental Hygiene. Important If item 27 is marked other than "natu any injury or other traumatic event, the Medical any injury or other traumatic event, the Medical Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) MEDICAL 12 HOUSEKEEPER Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည EDITH BUTLER GUSSIE HOLLOWAY 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <u>JANICE MOORE/DAUGHTER</u> MAIN ST. BALTIMORE, MARYLAND 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) CROWNSVILLE VET.CEM. 4-22-2011 CROWNSVILLE, MARYLAND 21. Signature of Funeral Service Licensee 22. Name and Address of Facility JAMES A. MORTON & SONS F.H., INC. ames q. W 1701-31 LAURENS ST. BALTIMORE, MD 23a. Par. 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Onset and Death Immediate Cause (Final Physician/ rny 0 C ord disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions. Examine if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of): Cause (Disease or linjury attending physician and for use as the burial-trans that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical Hospital or Attending Physician: The law requires that the death certificate be 24 hours after death.
Funeral Director: After this certificate has been signed by the attending physicis Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months? Month Day Year Pregnant at time of death 9 Unknown been signed by the should be detached 1 L Yes 2 Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown After this certificate has been funeral director, page 2 should 24b. Were autopsy findings available prior to completion of cause of death? di seate artery 24a. Was an autopsy performe 1 ☐ Yes 2 ☐ No Be (25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital Other: 4 Nursing Home 5 Residence 6 Other (Specify) ဥ 1 Yes 1 Inpatient 2 R/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: work?
1 Yes 2 No 1 Natural 5 Pending ☐ Accident ☐ Suicide Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) completed filled in by 4 Homicide 24 hours a Funeral I Medical Sertifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check within 2 only one) Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certific

State Registrar 30. Name and address of person who completed cause of death (Item 23a) (Type, Prin

Ja

APR 15

ere 31. Date filed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible,

State of Maryland / Department of Health and Mental Hygiene 1 Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Day Year **Physician** AM 24 2011 12 Bernice M. Moore /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Baltimore Sauce Hospital Rosedele FRANKLIN Birthplace (State or Foreign Country) If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Mar 20, 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Days Hours 1 □ M 2 🛱 F 1923 88 Washington DC Director 579-22-1761 Usual Residence of Decedent death with the Maryland 10c. City, Town or Location 10d. Inside City Limits permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the "Acalcal Exprantment must be prefitted at any injury or other traumatic event, the "Acalcal Exprantment must be prefitted at approxe." 10a. State 1 ☐ Yes 2√∑ No Director MD Nottingham Baltimore 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 21236 USA 4218 Winterode Way Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S Armed Forces? 11. Marital Status 1 ∐Yes 2 No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married 21215-0036 white 1 □Yes 2**X** No Specify: ð 3X Widowed 4 □ Divorced Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) office manager Pentagon unk Maryland unk 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Nancy J. Mease/sister in law 4218 Winterode Way Nottingham, MD Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 Removal from State 4 X Donation 5 ☐ Other (Specify) 21. Signature of Funeral Struct State Anatomy Board 655 W. Baltimore Street 21201 Baltimore, MD 23a. Part 1. Anter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, o heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cau (Final disease or condit resulting in death) Physician hours tempty sis /Medical Due to (or as a consequence of): Examiner Due to (or as * consequence of) Months Sequentially list conditions, Examiner if any leading to immedia cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-transit Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Year Day in the past 12 months? 5 Other (specify) I □Yes 2 □No 9 I Inknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Fibrille to 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No 24a. Was an perform this certificate 2 No ardiomyopathy 1 TYes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1 Yes 2√No Certification: To 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death After 1 1 Natural 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident after death Director: 3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 24 hours a Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical 29a. Certifier (Check only one) and manner stated. within 2 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License numbe 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 21222 6730 Holabird Gallo Dorgh 31. Date filed (Month, Day, Year) 32 Registrar's Signatur State APR 5

DHMH 17 Rev 1/2001

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month 04 Year 3:22 AM nowle ames 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Harford Memorial Hospital Havre de Grace Harford If Under 1 Year | If Under 24 Hrs.
Months Days Hours Min. Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 8. Date of Birth (Month, Day, 7. Age (In vrs. last birthday Vear 1 X M 2 □ F 57 8, 1954 Maryland Mar 217-64-4990 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 1 ☐ Yes 2√∑ No MD Harford Aberdeen 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 31 Pritchard Avenue #A2 21001 USA 12. Was Decedent Ever in U.S Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11 Marital Status Black, White, etc. 1 ∏Yes 2 ∏ No If Yes, Give Year or Dates: 1 X Never Married 2 ☐ Married 1 □Yes 2X No white Specify: 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 12 laborer power plant 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Albert Mumpower Rose Mary Partridge 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Bonnie Anderson/sister 2226 Nodleigh Terrace Jarrettsville, MD 21084 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4□Donation 5☒Other (Specify) in state State Anatomy Board 655 W. Baltimore Street Signature of Funeral Surv S. Wade baltimore, MĎ 21201 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, on heart failure. List only one cause on pach line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Due to (or as a consequence of) eV Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of): IF FEMALE: If yes, outcome of pregnancy

1 ☐ Live birth 2 ☐ Fetal death

4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 🗆 Ectopic pregnancy Month Day Year 5 Other (specify) ☐Yes 2☐No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 No 1 🗌 Yes 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy perform 2 No 1 ☐ Yes 25. Was case referred to medical examiner?
1 ☐ Yes 2 ☑ No 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 2 ER/Outpatient 3 DOA 1 Inpatient 27. Manner of Death 1 Natural 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 □ Suicide

burial-1 physician 68760 as the the attending Division of Vital Records, P.O. Box nse Por signed by the a page 2 should peen MUMPOLLEVI After this certificate has Physician; or Attending

Hospital

death. within 24 hours after death

To the Funeral Director: ,
completely filled in by the f

Examine

Physician

Examiner

Funeral

Director

28a-f show

Director

by Funeral

Completed

Be

2

permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylau Department of Health and Mental Hygiene. Important; If the 23 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, It is leaded Exprine must be notified as any Injury or other traumatic event, It is leaded Exprine must be notified as

Physician /Medical

Examiner

Maryland 21215-0036

Baltimore,

/Medical

Physician/Medical Completed by Be Certification: To

Medical

State Registrar (Check only one)

4 ☐ Homicide

29a. Certifier

29b. Signature and title of dertifier

determined

Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

29c. License number

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

30. Name and address of person muleted cause of death (Item 23a) (Type, Print) das theu a

31. Date filed (Month, Day, Year) APR 5

Registrar's Signatur 32

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. Decedent's Name (First, Middle, Last) 2. Date of Death Month-**Physician** eanna Kamona tpr.1 2011 205 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** N/A The Johns Hopkins Hospital **Baltimore City** If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign 5. Social Security Number 8. Date of Birth (Month, Day, Year) 7. Age (In yrs. last birthday) **Funeral** Days Hours 1 □ M 2 🗓 F 219-89-6152 Yrs. Maryland February 9, 2011 **Director** Usual Residence of Decedent death with the Maryland 10d. Inside City Limits 10a. State 10b. County 10c. City. Town or Location ir than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at Maryland Director n/a Baltimore 1 X Yes 2 □ No 10e. Street and Number 10f. Zip-Code 10g. Citizen of What Country? 1667 E. Coldspring Lane 21218 United States Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 XXNo If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Pages 1 and 2 should be filed within 72 hours after 1 X Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 💢 No Specify: <u>چ</u> Specify: black 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) al Hygiene. Elementary/Secondary (0-12) College (1-4 or 5+) 0 not employed n/a 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be is marked of Daniel Nicholson Ciarrie Banks 2 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 s
Department of Health ar
Important: If item 27 is
any injury or other trau 1667 E. Coldspring Lane Ciarrie Banks/mother 21218 Baltimore, MD 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 X Burial 2 Cremation 3 Removal from State Dulaney Valley Mem GardApr. 18,2011 Timonium, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service License John O. Mitchell IV, Funeral Services of Dulaney Valley ohn O. Mitchell 200 E. Padonia Rd. Timonium, Maryland 21093 P.A. 23a. Pa./ . Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, sh. ck, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final a. Rispinatory un to (or as a consequence of): **Physician** disease or condition resulting in death) /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examine or Attending Physician: The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of) nding physician Division of Vital Records, P.O. Box 68760, Physician/Medical as the IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant Live birth 2 Fetal death Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 No Month Day ☐ Pregnant at time of death
☐ Unknown 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 ☐ Probably 4 ☐ Unknown Completed 24a Was an 24b. Were autopsy findings available prior to completion of cause of death? autopsy performed? X Yes 2 No 2 No 1 Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital: Other: 4 Nursing Home 5 Residence 1 ☐ Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA မ 6 Other (Specify) 27. Manner of Death
1 Natural
2 Accident 28a. Date of Injury (Month, Day Y 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 5 Pending investigation 1 🗌 Yes Director: A 3 Suicide Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 - Homicide within 24 hours a Hospital Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (check only Medical Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. one) 29b. Signature and 29c. License number 29d. Date signed (Month, Day, Year) - 600 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar

DHMH 17 Rev 1/2001

State

32. Registrar's Signature

Wadio

31. Date filed (Month, Day, Year)

600 North Wolfe St, Baltimore, MD, 21287

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygienes - State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2 Date of Death 3. Time of Death nonth C 0,00 Physician/ RL se. Medical 4a. Facility Name (if not institution, ive street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner BALTIMORE SEASONS HOSPICE ON NORTHWEST HOSPITAL RANDALLSTOWN If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) Social Security Number Birthpia. Country) MD **Funeral** 1 □ M 2 🕱 F Days Hours 04776/1931 Director 79 213-28-7607 Usual Residence of Decedent 28a-f shov 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location must be notified at Funeral Director filed within 72 hours after death with the Maryland 1 🗌 Yes 2 ី No OWINGS MILLS MD BALTIMORE 10e. Street and Number 10f. Zip Code ò 10g. Citizen of What Country? items 23a USA 21117 8019 VALLEY MANOR ROAD 11. Marital Status 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian. other traumatic event, the Medical Examiner Armed Forces?

1 Yes 2 No Black, White, etc. ò Completed by 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 No Specify: If Yes, Give Year or Dates Specify: WHITE "natural", 3 🕅 Widowed 4 🗌 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry permit. Page 1 and 2 should be filed within 72 l. Department of Health and Mental Hygiene. Important: If item 27 is marked other transman any injury or other traumatic event once. (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) OWN HOME HOMEMAKER Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 KAZ GLICK BELLE BENJAMIN 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) MEADOWSWEET ROAD, PIKESVILLE, MD 21208 BRIAN NEEDEL / SON 20a. Method of Disposition
1

Burial 2 □ Cremation 3 □ Removal from State 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place) 4 ☐ Donation 5 ☐ Other (Specify) 04/13/2011 ROSEDALE, MD FORBAND CEMETERY Signature of Funeral Service Licenses 22. Name and Address of Facility SOL LEVINSON & BROS., INC. MD 21208 PIKESVILLE, 8900 REISTERSTOWN ROAD, Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each ling. Immediate Cause (Final Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, reading to immediate cause. Enter Underlying Physician/Medical Examiner Due to (or as a consequence or). Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or iinjury that initiated events resulting in death) Last Due to (or as a consequence of): P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Fctopic pregnancy in the past 12 months?

1 Yes 2 No 5 Other (specify) Month Day Year Pregnant at time of death been signed by the s should be detached t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Division of Vital Records, 1 Tyes 3 Probably 4 Unknown 2 7 No Be Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an autopsy performe 24 hours after death.

Funeral Director: After this certificate 25. Was case referred to medical 26. Place of Death (Check only one) funeral director, examiner? Hospital Other: 2 2 No Certificate: To 1 Yes 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 28a. Date of injury (Month, Day, Year) Manner of Death 28b. Time of 28c. Injury at work?
1 Yes 28d. Describe how injury occurred 1 Natural injury 5 Pending 2 No Accident Investigation 6 Could not be 3 ☐ Suicide 4 ☐ Homicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by determined Medical 29a. Certifie 🔛 certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. completed (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. within 2 To the F only one) 29b. Signature and title o 30. Name and address of person who completed cause of death (Item 23a) Type, Print)

6 DHMH 17 Rev 7/2009

State Registrar 31. Date filed (Month, Day, Year)

32

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2011 2. Date of Death 3. Time of Death Month DC Day Physician/ 0605 Thomas W. O'Keefe Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death **Examiner** Salisbury Rehabilitation + Nursing (SPUR omico 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign Social Security Number If Under 24 Hrs If Under 1 Year Funeral Days Hours (Month Day, Year) New York 1 🕅 M 2 🗆 F Months Min 096-28-6773 May Director 74 Usual Residence of Decedent show 10d. Inside City Limits permit. Page 1 and 2 should be filed within 72 hours after death with the Manyland Department of Health and Mental Hygiene. Important: If tiem 27 is marked other than "natural", or items 23a or 28a-f sho any injury or other traumatic event, the Medical Examiner must be notified at any injury or other traumatic event, the Medical Examiner must be notified at 10b. County 10c. City, Town or Location Director 1 Yes 2X No Berlin Worcester MD 10f, Zip Code 10g. Citizen of What Country? Funeral USA 21811 12 Trinity Place 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 24 No If Yes, Give Year or Dates. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status Black, White, etc. Completed by 1 X Never Married 2 Married white Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: 3 Divorced 4 Divorced 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life, DO NOT use retired) (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) food industry chef æ 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Sadie LaRusso Arthur O'Keefe homas 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 11604A Shipwreck Road ocean City, MD Kimberly Ford/friend 20b. Place of Disposition (Name of 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☑ Other (Specify) in State cemetery, crematory or other place) Signat ... f Euneral Service Liven State and Andrew Board 655 W. Baltimore Street Director Baltimore, MD 21201 Part Lenter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ year disease or condition resulting in death) Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury Examine Due to (or as a consequence of) Hospital or Attending Physician: The law requires that the death certificate be executed for use as the burial-transit and that initiated events Due to (or as a consequence of) resulting in death) Last by the attending physician Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? Month Day Year Pregnant at time of death 🗌 Yes 2 🗌 No cate has been signed by the page 2 should be detached 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available 24a Was an prior to completion of cause of death? After this certificate has autopsy performe 2 No 1 Yes 25. Was case referred to medical examiner?

1 Yes 2 No Be 26. Place of Death (Check only one) funeral director, Other: 4 Nursing Home 5 Residence 6 Other (Specify) ၉ 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28h Time of 28d. Describe how injury occurred 28c. Injury at Certificate: ☐ Natural 5 Pending work? 1 ☐ Yes 2 ☐ No To the Hospital or Attendin within 24 hours after death.

To the Funeral Director: Aft completed filled in by the fur Investigation 6 Could not be Accident Acciue. 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 29c. License number 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) William H. Ro 31. Date filed (Month, Day, Year) State APR Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

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State of Ma	ryland /	Depa	artment of	f Health	and Mei	ntal Hygie	ne

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>		4a. Faci	lity Name (if not institution		treet and nu	imber)			o. City, To Baltim		Location of	Death		4c. (County of D	eath		
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9, MD 21215-0036 and 2 should be filed within 72 hours after eath and Mental Hygiene. tem 27 is marked other than "natural", fraumatic event, the Medical Examiner.		Co		ine	Coo	raer			0605		ShE	ord)	Nax	W	seds	tock	. 1	15 OM	163
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Division of Vital Records, P.O. I tal or Attending Physician: The law requires that the 1rs after death. *I Director: After this certificate has been signed by the led in by the funeral director, page 2 should be detached.	à	Part II. C	ther signif	ficant condit	ons co	ntributing to	death but no	ot resultir	ng in the und	lerlying o	cause giv	ven in Part	1.					e cause of dea	
cords, F law requires has been sign	Completed													24a. Was a autop	sy	prior	to con	osy findings a npletion of ca	
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ion tendin eath. for: A	Certification:	1 N	latural scident	5 Pend	ing tigation		Day, Year) -28-11	fd	8:00	am.	1 Ye	es 2 X N	su se	bject dated	beca	ame hy	ypo	xic wh	ile
ivis lor At after d Direct	ţįĮ	- [uicide	6 Coul	not be		of Injury - A				office bui	ilding, etc.	28f	Location (S	treet and	Number or	Rural	Route Numb	er, City
Ospital hours uneral ly filled		4 H	lomicide		mined	(Specify)		_	y cent				34	U Co.	Tumb:	la,Md.			73
Division of Vital Recc To the Hospital or Attending Physician: The law within 24 hours after death. To the Funeral Director: After this certificate ha completely filled in by the funeral director, page 2	10	(Check on one)	y	Certifying Ph Medical Exam	niner:On		f examination												
F \$ F 3	ž	29b. S gr	ature and	title of certifie							License					te signed (Month	, Day, Year)	
		<u>()</u>	-bh	toke	w)						O.C.M	I.E.			April 7	7, 2011 ————			
No of the			and addre	MD. A			e of death (It I Examine		1 Penn S	treet, l	Baltim	ore, MD	21201						
_	ate	31. Date	filed (Mont		1		gistrar's Sign							-					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First Middle | ast) 2. Date of Death April Physician/ Dav 2011 8:05 a.M 9 Gordon Frederick O'May Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Baltimore Dundalk Heritage Center 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday, If Under 1 Year If Under 24 Hrs. 8. Date of Birth **Funeral** April 1, Year 1928 Hours 1 🛛 M 2 🗆 F Maryland Director 83 218-22-8486 Usual Residence of Decedent show 10d. Inside City Limits 10a, State 10h County 10c. City, Town or Location within 72 hours after death with the Maryland Director ms 23a or 28a-f s must be notified 1 Yes 2 No Maryland Dunda1k Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21222 Funeral 1904 Dineen Drive United States items (13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11 Marital Status Examiner Black, White, etc. 10, 1 Never Married 2 Married þ Maryland 21215-0036 White 1 ☐ Yes 2 X No Specify. WW II Specify: "natural", Completed 3 Widowed 4 Divorced Year or Dates Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b, Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) permit. Page 1 and 2 should be filed within 7. Department of Health and Mental Hygiene. Important: If item 27 is marked other than any injury or other traumatic. Elementary/Seconday (0-12) College (1-4 or 5+) Analyst - Bethlehem Steel Corp. Stee1 12 years 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Martha E. Liedtke John S. O'May 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Dundalk, Maryland 21222 1904 Dineen Drive Kathleen A. O'May (Wife) Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Cther (Specify) Baltimore, Maryland 4/13/2011 Oak Lawn Cemetery 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Duda-Ruck Funeral Home of Dundalk, Inc. Dundalk, Maryland 21222 7922 Wise Avenue art 1. Enter the disease, or complications that caused the death, Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Immediate Cause (Final Onset and Death NGIOCARCING MI Physician/ disease or condition Medical resulting in death) as a consequence of) Examiner Sequentially list conditions, if any local cause. Enter Underlying Cause (Disease or linjury that initiated events Examine Due to for as a consequence of the attending physician and hed for use as the burial-transit Due to (or as a consequence of): resulting in death) Last Physician/Medical To the Hospital or Attending Physician: The law requires that the death certificate be within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physicia completed filled in by the funeral director, page 2 should be detached for use as the burn IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) in the past 12 months? Month Day Year 9 Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Division of Vital Records, 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 2 No 1 Yes 25. Was case referred to edical Be 26. Place of Dea - Check only one) examiner? ပု No 1 Inpatient 2 ER/Outpatient 3 DOA Nursing Home 5 Residence 6 Other (Specify) 27. Manna of Death 28b. Time of Certificate: 28a. Date of injury 28c. Injury at 28d. Describe how injury occurred (Month, Day, Year) ✔ Natural 5 Pending 1 Yes 2 No Investigation 6 Could not be Accident 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a, Certifier (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifie 30. Name and address of person who completed ca 1671 Place Davidalk MO 21222

DHMH 17 Rev 7/2009

State Registrar 31. Date filed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Time of Death Day 2011 Physician/ April 4:00 A.M Benjamin Guy Peterson 13 Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Anne Arundel Crownsville Fairfield Nursing Center Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 XM 2 □ F Months Days Hours April 27, 1934 Louisiana 76 456-54-1980 Director Usual Residence of Decedent 23a or 28a-f show 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Examiner must be notified at Director D.C. Washington 1X Yes 2 No 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? Funeral 700 7th Street S.W. #702 United States death with 20024 items Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Bace - American Indian. Armed Forces? Black, White, etc. 0 1 Never Married 2 Married þ X Yes 72 hours after Baltimore, Maryland 21215-0036 If Yes, Give 1956–1965 Year or Dates. 1 ☐ Yes 2 No Specify: Specify: White "natural", 3 Widowed 4 X Divorced Completed the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Civil Engineer Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) permit. Page 1 and 2 should be filed within 72 Department of Health and Mental Hygiene. Important: If item 27 is marked other than "any injury or other traumatic event; the Meg Elementary/Seconday (0-12) College (1-4 or 5+) **5+** U.S. Government Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) K.C. Peterson Ruby Halbert 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Anne P. Rhodes/Daughter 1714 Fairhill Drive, Edgewater, MD 21037 20a. Method of Disposition 20b. Place of Disposition (Name of George Wash). University Medical Center 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State Washington, D.C. 4 ☑ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Columbia Mortuary Services, P.A. teral Service I. /M00969 wi 9013 Annapolis Road, Lanham, MD 20706 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) lak Medical Due to (or as a consequence of) Examiner Sequentially list conditions Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of): To the Hospital or Attending Physician: The law requires that the death certificate be executed and for use as the burial-tran that initiated events Due to (or as a consequence of): resulting in death) Last attending physician Physician/Medical Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23h. Was decedent pregnant 23d. Date of delivery 3 - Ectopic pregnancy in the past 12 months? Month 4 Pregnant g Unknown Pregnant at time of death 5 Other (specify) detached 9 Unknown P.O. I ģ signed to Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Division of Vital Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🔀 Unknown Completed director, page 2 should peen 24b. Were autopsy findings available prior to completion of cause of death? 24a, Was an has autopsy perforn After this certificate 1 Yes 2 No 2 DINO Yes Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? 2 No မ 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) within 24 hours after death.

To the Funeral Director: After thi
completed filled in by the funeral is 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred Natural 5 Pending work? 1 🔲 Yes 2 🗌 No Investigation 6 Could not be Accident Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) Signature and title of ertifie D38958

State Registrar cause of death (Item 23a) (Type, Print)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene, 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Year Physician 6:14 PM March 31, 2011 Ivory Na'shawn Preddy /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Upper Chesapeake Hospital Harford Bel Air Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday **Funeral** 1 3M 2 ☐ F Director N/A 2011 Maryland Usual Residence of Decedent death with the Maryland 10d. Inside City Limits 10a. State 10c. City, Town or Location 10b. County permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylar Department of Health and Mental Hygiene. Important: If item 27 Is marked other than "natural", or Items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at 1 ☐ Yes 2 No Directo MD Harford Edgewood 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 1951 Edgewater Dr. Apt. G 21040 United States Funeral 14. Bace - American Indian. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 ☐ Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 No Specify. ģ 3 Widowed 4 Divorced Black Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) N/A N/A 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Reginald A. Preddy Lashawn M. Bush ၉ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Lashawn M. Bush /Mother 1951 Edgewater Dr. Apt. G Edgewood, MD 21040 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition Apr 08 4 ☐ Donation 5 ☐ Other (Specify) 2011 Beltsville, Maryland Chesapeake Crematory MU1585 22. Name and Address of Facility 21. Signature of Funeral Service Licens Cremation and Funeral Alternatives Kelse 8717 Green Pastures Drive Towson Maryland 21286 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Physician TED /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Errier Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner attending physician and Due to (or as a consequence of) Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy Month Day Year in the past 12 months? 4☐Pregnant at time of death 5 ☐ Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 2 No 1 Yes 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy perform 1 ☐ Yes 2□ No funeral director, 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To this 28a. Date of Injury (Month, Day Year) 28b. Time of Injury Manner of Death 28d. Describe how injury occurred 28c. Injury at Work? I or Attending Faffer death. 5 ☐ Pending investigation 1 Natural 2 Accident 1 ☐ Yes 2 ☐ No Director 6 ☐ Could not be 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 124 hour. Hospital Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier completely and manner stated. the within To the 29d. Date signed (Month, Day, Year) 29c. License number 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

State Registrar

DHMH 17 Rev 1/2001

ORIGINAL

ntani, M.D. 520 upper Chesapoake Dr. Swite 3d Bel 4ir, mo 21014

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death April Physician/ Robert J. Parsons, Sr. 2011 10:45P. [™] Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Baltimore Essex Riverview Nursing Home Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign 7. Age (In vrs. last birthday) **Funeral** Months Days Hours June 20,1922 214-12-0903 Yrs. 88 Maryland **Director** Usual Residence of Decedent or than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at 10b. County 10a. State 10c. City, Town or Location 10d. Inside City Limits Director Baltimore Yes 2 No Maryland 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral U.S.A. 21214 3203 Beverly Road death Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, 11. Marital Status Armed Forces Black, White, etc 1 Never Married 2 Married 1X Yes 2 \square No If Yes, Give Year or Dates. 42-46þ Maryland 21215-0036 1 ☐ Yes 2X No Specify: Specify: White 3 Widowed 4X Divorced Completed 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Marine Terminal Crane Operator traumatic event, Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) should be file and Mental F မ Catherine Koenig Emory Parsons 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 sh
Department of Health ar
Important: If item 27 is
any injury or other trau 8717 Stockwell Road, Parkville, Maryland 21234 Beth E. Menefee Baltimore, 20a. Method of Disposition 20c. Location - City or Town, State 20b. Place of Disposition (Name of 1 X Burial 2 Cremation 3 Removal from State cemetery, crematory or other place) 4 Donation 5 Other (Specify) Holy Redeemer Cemetery 4-15-11 |Baltimore,Maryland 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Marzullo Funeral Chapel, P.A. 6009 Harford Road, Baltimore, Maryland 21214 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final (graiamychally Onset an Death Phyllician/ 10 chamic disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of) Examin Cause (Disease or linjury that initiated events resulting in death) Last Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-tran Due to (or as a consequence of): Physician/Medical Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregna 5 ☐ Other (specify) Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day Year Pregnant at time of death the P.O. ed by the Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Records, 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 1000m 24a. Was an cate has I performed Yes 2 1 Yes 2 1 No certificate Division of Vital 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? 2 No Other: 1 🗌 Yes ٩ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) this hin 24 hours after death.

the Funeral Director: After this
mpleted filled in by the funeral i 28a. Date of injury (Month, Day, Year) . Manner of Death 28c, Injury at work?
1 Yes 2 No 28b. Time of Certificate: 28d. Describe how injury occurred 1 Natural 5 Pending 2 Accident
3 Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) MD 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) M-D-21221 ASTERN BLUD. WASBEM 709. 31. Date filed (Month, Day, Year)
APR 15 2011 State

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. Decedent's Name (First, Middle, Last) 2. Date of Death Time of Death Physician Month Day 2011 6:30 P M Lauretta Julia Pleasant 04 11 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Montgomery Potomac Valley Nursing Home Rockville If Under 1 Year | If Under 24 Hrs. Date of Birth (Month, Day, 10 22 Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Months Days Hours 1 □ M 2 🕅 F 1941 MA 024-32-3432 Director Usual Residence of Decedent 2 should be filed within 72 hours after death with the Maryland n and Mental Hygiene.

Is marked other than "natural", or items 23a or 28a-f show 10b. County 10c. City, Town or Location 10d. Inside City Limits other traumatic event, the Medical Examiner must be notified at 1 XYes 2 □ No Director Rockville Montgomery 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 20850 1235 Potomac Valley Rd. USA 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 □Yes 2 THO Specify: 2 Specify: Black 3X Widowed 4 □ Divorced Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life, DO NOT use retired) I Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Clerk JC Penney 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Thomas Walker Wallace JR. Mayaline Jamerson 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Pages 1 and 2 sl ment of Health an ant: If Item 27 is 1 16409 Everwood Ct. Bowie, MD 20716 Kimberly J. Davidson/Daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State permit. Pages Department of Important: If It any Injury or o once. 1 Burial 2 □ Cremation 3 □ Removal from State Silver Spring,MD Gate of Heaven 04/19/2011 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Marshall-March Funeral Home C Indees 4217 9th St. NW Washington, DC 20011 Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each li Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to infinediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to for as a consequence of Due to (or as a consequence of) Box 68760. or Attending Physician; The law requires that the death certificate be Physician/Medical 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 X No Month Day Year Pregnant at time of death 5 ☐ Other (specify) □Yes Division of Vital Records, P.O. 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4X Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed?
Yes 2 XNo 1 ☐ Yes 2 ☐ No 1 ☐ Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 🔀 Nursing Home 5 🗆 Residence 6 🗀 Other (Specify) 1 Yes 2 No Certification: To 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident within 24 hours after death

To the Funeral Director:
completely filled in by the 6 Could not be determined 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 29a. Certifier 1 🗗 Certifying Physician: To the best of my knowledge, death occurred et the time, date and place, and due to the cause(s) and manner as stated. Medical (Check only one) Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

State Registrar

title of certifier

Sayed Elsayyad, MD 31. Date filed (Month, Day, Year)

Mn.

and address of person who completed cause of death (Item 23a) (Type, Print)

29b. Signature a

30. Name

32. Registrar's Signature

DHMH 17 Rev 1/2001

29c. License number

1235 Potomac Valley Rd. Rockville, MD 20850

69148

29d. Date signed (Month, Day, Year)

04/11/2011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene) Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ April 1 Melvin Douglas Robinson Sr. 201**T** 1:33 DM Medical 4a. Facility Name (if not institution, give street end number) 4b. City, Town, or Location of Death Examiner 4c. County of Death 12575 Triadelphia Road Ellicott City Howard Social Security Number Sex 1X□ M 2 □ F 7. Age (In yrs. last birthday, If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Hours 11_1()_192;3^(ear) Country) Director 463-72-4905 67 NC Usual Residence of Decedent 28a-f shov 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits filed within 72 hours after death with the Maryland Directo must be notified MD Howard Ellicott City 1 Yes 2 No ò 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 23a Funeral 21042 USA 12575 Triadelphia Road Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, the Medical Examiner Armed Forces?
1 X Yes 2 If Yes, Give Black, White, etc. 0 ģ 1 Never Married 2 Married 2 🗀 No Maryland 21215-0036 1 Yes 2 XNo Specify: African-American "natural" Completed 3 Widowed 4 Divorced Year or Dates 15. Decedent's Education 16a Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) I Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) U.S. Dept. of Agriculture Accountant other traumatic event. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) and Mental F is marked of pe Charlie R. Robinson Margaret Hawkins 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) of Health of item 27 i 12575 Triadelphia Road, Ellicott City, MD 21042 Barbara Robinson/Wife and 2 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Department of I Important: If its any injury or ot 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Crestlawn Cemetery 4-16-2011 Marriottsville, MD 21. Sign were of Funeral Service License 22. Name and Address of Facility lie Funeral Home P.A. of Palto Co. 9200 Liberty Road, Randallstown, MD 21133 23a. Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final LUNG Physician CANCIER years disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or imjury Examine Due to (or as a consequence of): bunial-transit Cause (Disease or I that initiated events Due to (or as a consequence of): resulting in death) Last attending physiciar Physician/Medical that the death certificate be Box 68760 the IF FEMALE: nse 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy for in the past 12 months? Month Pregnant at time of death 5 Other (specify) Yes 2 No be detached g Unknown 9 Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ۾ Division of Vital Records, Completed 1 Tes 2 No 3 Probably iis certificate has been s director, page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed Yes 2 No or Attending Physician: 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 1 \(\subseteq \text{Yes} 2 No Other: မ 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) within 24 hours after death.

To the Funeral Director: After this funeral 27. Manner eath 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred Natural 5 Pending Accident 1 ☐ Yes 2 ☐ No Investigation 6 Could not be filled in by the 3 Suicide 4 Homicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined the Hospital Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a, Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) ture and title of certifier 29d. Date signed (Month, Day, Year) eted cause of death (Item 23a) (Type, Print) KNOCE N. Dr. CowmBIA MD 21045 5450 Date filed (Month, Day, Year) 32. Registrar's Sign APR 1 5 201 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Physician/ Month Kevin NMN Romero 11:34 Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death National Institutes of Health Bethesda Montgomery If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country)
 NY Social Security Number **Funeral** 6. Sex 14 M 2 □ F 7. Age (In yrs. last birthday) 8. Date of Birth 02 28 Days Hours 196<u>2</u> Director 144-60-6354 49 Usual Residence of Decedent 28a-f shov 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director ral", or items 23a or 28a-f s Examiner must be notified 1 XYes 2 No MD Baltimore Arbutus 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 920 Wilton Drive USA 21227 12. Was Decedent Ever in U.S Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 1 Yes 2 No If Yes, Give 1980-1984 Year or Dates. þ 1 Never Married 2 X Married Baltimore, Maryland 21215-0036 72 hours after Puerto 1 X Yes 2 ☐ No Specify: Specify: White "natural", 3 Divorced 4 Divorced Completed Rican traumatic event, the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) and Mental Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) Maintenance Supervisor Equity Residential Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ၉ Patria Martin Ortiz Norrega 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 sl Department of Health a Important: If item 27 is any injury or other tra 920 Wilton Drive Arbutus, MD 21227 Denise Romero/Wife 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date 1 Burial 2 XCremation 3 Removal from State cemetery, crematory or other place, 04/13/2011 | Alexandria, VA 4 Donation 5 Other (Specify) Metropolitan Crem. 21. Signature of Funeral Service Censee 22. Name and Address of Facility Marshall-March Funeral Home 4217 9th St. NW Washington, DC 20011 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter chaonying Examine Due to (or as a consequence of) and I-transit Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or iinjury that initiated events Due to (or as a consequence of): resulting in death) Last attending physician a for use as the burial-Physician/Medical P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) ____ in the past 12 months? Month Year Pregnant at time of death signed by the a d be detached f Yes 2 No Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Division of Vital Records, 2 No 3 ☐ Probably 4 ☐ Unknown cate has been sig page 2 should b Completed 1 Yes Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 1 Yes 2 No Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) funeral director Hospital 2 □ 💢 Other: 1 Tyes ြု 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending injury work? 1 ☐ Yes 2 ☐ No after death.

Director: Aft in by the fur 2 Accident Investigation 6 Could not be within 24 hours after de To the Funeral Directo completed filled in by the 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 - Homicide determined Medical certifying Physiciap the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: Of the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check 3 🗆 Certifying Nuyse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifie 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 9000 Rockville P -3224 Betrevel MD 20892 IOCRC 31. Date filed (Month, Day, Year) State Registrar

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 1 - For State Registrar State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month Day Judith Erickson Starks 4:50 A <u> April</u> 13, 2011 Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Montgomery Silver Spring 12609 Billington Road Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Months Days 1 \(\tag{M} 2 \(\tag{N} \) F Hours Jul Honth Oay, 1922 Director 476-14-7412 88 Minnesota Usual Residence of Decedent 28a-f shov ms 23a or 28a-f sho must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits death with the Maryland Director 1 ☐ Yes 2X No MD Silver Spring Montgomery 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? Funeral 12609 Billington Road 20904 USA items Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. Race - American Indian, Black, White, etc. Examiner Armed Forces?

1 Yes 2 No 5 þ 1 Never Married 2 Married 1 Yes 1 Baltimore, Maryland 21215-0036 nan "natural", Medical Exan 1 ☐ Yes 2X No Specify. Specify: White 3 XWidowed 4 Divorced Completed Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) 2 should be filed within 72 in and Mental Hygiene. College (1-4 or 5+) Elementary/Seconday (0-12) the Own Home Homemaker other traumatic event, Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ၉ Ida Voldahl Ole B. Erickson 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1 and 2 so of Health a item 27 i Marcia Phillips/daughter 878 Mount Carmel Rd. Orrtanna, PA 17353 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State permit. Page 1 Department of I Important: If it any injury or o 1 ☐ Burial 2 🛛 Cremation 3 ☐ Removal from State cemetery, crematory or other place) 4 ☐ Donation 5 ☐ Other (Specify) Journey Crematory 4/15/2011 Woodbine, Maryland 21. Signature of Funeral Service Lic Going Home Cremation Service P.O. Box 784 Beverly L. Heckrotte, P.A. Clarksville, MD 21029 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate shock, or heart failure. List only one cause on each line Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) Senile Dementia Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to in insolute cause. Enter Underlying Cause (Disease or iinjury Examine Due to (or as a consequence of). attending physician and for use as the burial-transit or Attending Physician: The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?
1 Yes 2 X No Month Day Year Pregnant at time of death detached signed by i Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by Pulmonary Fibrosis 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🔀 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy perform 1 ☐ Yes 2 🛛 No 2 X No funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital 1 🗆 Yes _2 🔀 No Other: ျှ 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 X Residence 6 ☐ Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 X Natural 5 Pending nours after death. neral Director: Aff d filled in by the fu 1 🗌 Yes 2 🗌 No ☐ Accident ☐ Suicide Investigation 6 Could not be 3 ☐ Suiciae 4 ☐ Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Hospital within 24 hours

To the Funeral Medical 1 XCertifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifier 3 🗆 Certifying Nurse Practioner. To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) D37142 April 13, 2011 dress of person who completed cause of death (Item 23a) (Type, Print)

-bù

DHMH 17 Rev 7/2009

State Registrar Coleman, M.D.

31. Date filed (Month, Day, Year)

6001 Muncaster Mill Rd. Rockville, MD 20855

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend item 28e per me 2915 5-20-11 by State of Maryland Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. Ne. 2. Date of Death 1. Decedent's Name (First, Middle, Last) Apr Day 101 **Physician** 79 2011 (me /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner #132 SILVEX 5 T 100711 30mes 8 pri Birthplace (State or Foreign Country) If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, 5. Social Security Number 7. Age (In yrs. last birthday, **Funeral** Hours 1 □ M 2 🛣 F Oct 1. Massachussetts 63 Director 030-38-0208 Usual Residence of Decedent 2 should be filed within 72 hours after death with the Maryland and Mental Hygiene.

Is marked other than "natural", or items 23a or 28a-f show 10d. Inside City Limits 10c. City, Town or Location 10a State 10b County Pages 1 and 2 should be filed within 72 hours after death with the Maryla nent of Heatith and Mental Hygiene.
ant: If item 27 Is marked other than "natural", or items 23a or 28a-f shov ury or other traumatic event, the Medical Examinant to matter the medical Examination. 1 ☐ Yes 2 X No Director Silver Spring Maryland Montgomery 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number United States 3431 S. Leisure World Boulevard #882D Funeral 14. Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 XNever Married 2 Married 1 ☐ Yes 2 🔀 No Specify. 2 White 3 Widowed 4 Divorced Completed 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Community College Secretary 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Bertille L. Silva Wilbur L. Sheffield ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 480 12th Street Brooklyn, NY 11215 <u>Wendy L. McIlwain /</u> Sister 3altimore, 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 1 ☐ Buria! 2 【Cremation 3 ☐ Removal from State permit. Page:
Department of Important: If any injury or once. 4 □ Donation 5 □ Other (Specify) Final Journey Crematory 4/12/2011 Woodbine, Maryland 22. Name and Address of Facility 21. Signature of Funeral Service Licenses Going Home Cremation Service P.O. Box 784 MO1251 Beverly L. Heckrotte, P.A. Clarksville, MD 21029 Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Gun **Physician** 5 hol disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, it mediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner law requires that the death certificate be executed burial-trar Due to (or as a consequence of): Box 68760, attending physician for use as the buria Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day Year in the past 12 months? 1 ☐ Yes 2 ☑ No 4 ☐ Pregnant at time of death 9 ☐ Unknown 5 ☐ Other (specify) P.0. detached 9 Unknown cate has been signed by page 2 should be detach 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Records, 2 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 Yes 2 2 No Physician: The 1 ☐ Yes 2 ☐ No certificate Vital : After this certifical funeral director, I 26. Place of Death (Check only one) 25. Was case referred to medical Be examiner? 1 Yes 2 □ No Other: 4 Nursing Home 5 Residence 6 Nother (Specify) In 5 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To Division of 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Hospital or Attending 1 Natural 5 Pending investigation Self-Inflicted 1 □Yes 2 No UnKM 5 2011 Sun Jhol death. 24 hours after death. e Funeral Director: A letely filled in by the fi 2 Accident 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 6 ☐ Could not be 3 Suicide 4 ☐ Homicide hotel room 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical within 24 ho To the Fune completely f (Check only one) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) Signature and title of certifier, 1000425 1 mo DME 524 Hankesbury 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) OU BRECKER, MO 32. Registrar's Signature 31. Date filed (Month, Day, Year) parke APR 1 5 2011 Registrar

Please Type or Print in Black Indelible Ink, Ensure All Copies Are Legible.

Amend Item 26 per verb., g9 14.04/15/2011dhb

Certificate of Death

Reg. No. For State Registrar Decedent's Name (First, Middle, Last) 2. Date of Death Month April Physician/ William James Smith Sr. 2011 115AM Medical 4b. City, Town, or Location of Death 4a. Facility Name (if not institution, give street and number) 4c. County of Death **Examiner** Baltimore 2232 Monocacy Road Essex | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day Year) | 1952 | Min. | March 20, 1952 Birthplace (State or Foreign Country) Social Security Number 7. Age (In vrs. last birthday **Funeral** 218-58-6033 1 🕱 M 2 🗆 F 59 -58 MD Director Usual Residence of Decedent 28a-f show 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location Director 1 Yes 2 XNo MD Baltimore Essex 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 2232 Monocacy Road 21221 USA Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, 11. Marital Status Armed Forces?

1 Yes 2 No
If Yes, Give Black, White, etc. þ 1 Never Married 2 Married 1 Yes 2 No Specify: Specify: White Completed 3 Widowed 4 Wivorced Year or Dates. 16a. Decedent's Usual Occupation (Give kind of work done during most of working State Worker State Worker 15 Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) MD State 12th Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Frederick W. Smith Jane Cleaver 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Jane C. Smith /mother 2232 Monocacy Road Baltimore MD 21221 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 Kremation 3 Removal from State Bayview Crematory 4/7/11 Baltimore MD 4 Donation 5 Other (Specify) 21. Signeture of Funeral Service Licensee 22. Name and Address of Facility 300 Mace Ave. Balto. MD Connelly Funeral Home of Essex 21221 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate nterval Between Onset and Death Immediate Cause (Final ₽nysician/ Due to (or as a confiquence of): disease or condition resulting in death) artery miseus Medical Examiner 2001 - 2011 Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or imjury that in the control of the contro Examiner Due to (or as a consequence of): To the Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 3 Ectopic pregnancy

5 Other (specify) 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months?
1 ☐ Yes 2 ☐ No Month Year Unknown signed by the a g Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by 2 ☐ No 3 ☑ Probably 4 ☐ Unknown Diabetes Mellitus Type 1 🗌 Yes Be Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of abuso page 2 s autopsy performed death? 1 Yes 2 No certificate 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5X Residence 6 Other (Specify) Hospital 1 ☐ Yes 2 ☑ No မ 1 Inpatient 2 MER/Outpatient 3 IDOA this funeral 28c. Injury at work? 1 ☐ Yes 2 ☐ No 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28d. Describe how injury occurred within 24 hours after ueau...
To the Funeral Director, After formaleted filled in by the funer iniury 1 🗹 Natural 5 Pending 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29c, License number 29d. Date signed (Month, Day, Year) 4/7/11 D70113 Physician 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Baltimore mo Suire 309, Franklin Schare in 31. Date filed (Month, Day, Year) 32. Registrar's Signature State APR 15 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month 1 Smith 2011 Clayton Pau1 4:33am [™] Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death **Examiner** Carrol1 Westminster Summerville Assisted Living Birthplace (State or Foreign Country) MD 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth **Funeral** 1 ₹ M 2 □ F Months Hours June 3, Year 921 89 212-16-9734 Yrs Director Usual Residence of Decedent ms 23a or 28a-f show must be notified at 10b. County 10a. State 10c. City, Town or Location 10d. Inside City Limits Director 1 X Yes 2 No MD Carrol1 Westminster 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? USA 21157 45 Washington Road 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, traumatic event, the Medical Examiner Black, White, etc. 1 Never Married 2 XMarried 1 □XYes 2 □ No If Yes, Give 1 O "natural", or Completed by 21215-0036 Year or Dates. 1942–45 1 ☐ Yes 2 ☐ No Specify Specify. White 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) d Mental Hygiene. marked other than Elementary/Seconday (0-12) College (1-4 or 5+) 10 Assembly Supervisor Aircraft Be Baltimore, Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 1 and 2 should be file f Health and Mental H item 27 is marked o ဂ Lawrence Preston Smith Emma Bertha Schmidt 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) item 27 3615 Granite Road, Woodstock, MD 21163 permit. Page 1 and 2 Department of Health Important: If item 27 any injury or other to Mr. Barry P. Smith (Son) 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) 4/15/2011 Granite Presb. Cem. Woodstock, MD 22. Name and Address of Facility 21. Signature of Funeral Service License, HAIGHT FUNERAL HOME & CHAPEL, PA PO Box 195, Sykesville, MD 21784 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on eachyline. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition Physician/ Medical resulting in death) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events resulting in death) Lect. Exami law requires that the death certificate be executed resulting in death) Last attending physician for use as the buna Physician/Medical Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) in the past 12 months? Day Month Year Pregnant at time of death 1 Yes 2 No 9 Unknown 9 Unknown P.O. ed by t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ Records, 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Completed Were autopsy findings available prior to completion of cause of 24a. Was an autopsy performed? Yes 2 death? Be 25. Was case referred to medical Division of Vital 26. Place of Death (Check only one) examiner? ASSISKO 2 No မ 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify) hours after death.

neral Director: After this
d filled in by the funeral di 28c. Injury at work?
1 Yes 2 No 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred Certificate: Hospital or Attending 1XX Natural 5 Pending Accident
Suicide Investigation Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. completed Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. within 2 To the I only one 29b. Signature and title of certifie Name and address of person who completed cause of death (Item 23a) (Type, Print) MD Registrar's Signature 32. State Registrar

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene, 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Ann Saunders Month 201^{Year} Barbara 3:35p 13 April Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death Timonium4c. County of Death Stella Maris Hospice Baltimore 5. Social Security Number If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 8. Date of Birth **Funeral** Months Days Hours Min Sept 10 1 □ M 2 🔽 F ^{∌ar}1943 67 Yrs 217-38-5086 Director Usual Residence of Decede 28a-f show 10c. City, Town or Location the Medical Examiner must be notified at 10a State 10b. County 10d. Inside City Limits Director Abingdon MD Harford 1 Tes 2 XNo 10e. Street and Number ò 10f. Zip Code 10g. Citizen of What Country? USA items 23a Funeral 21009 2984 Raking Leaf Drive 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. "natural", or 1 Never Married 2 X Married þ Yes 2 XNo Baltimore, Maryland 21215-0036 Specify: white If Yes, Give Year or Dates 1 ☐ Yes 2 XNo Specify: 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Health and Mental Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) domestic homemaker Department of Health and Mental Hygi Important: If item 27 is marked othe any injury or other traumatic event, Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Grace Herring Joseph Arndt 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) $3102\ Rices\ Ln.,\ Windsor\ Mill,\ MD\ 21244$ William E. Saunders (spouse) 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 4-18-11 |Marriottsville, MD Lawn Memorial 22. Name and Address of Facility Haight Funeral Nome & Chapel 21. Signature of Funeral Service Licensee Parge Haight s P.O. Box 195 Sykesville, MD 21784 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Ph sician/ NEUROENDOCRINE disease or condition Medical resulting in death) Due to (or as a consequence of) **Examiner** Sequentially list conditions, Due to (or as a consequence or, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury that initiated events Examir ysician and e burial-transit The law requires that the death certificate be executed Due to (or as a consequence of): resulting in death) Last Physician/Medical Records, P.O. Box 68760 phys the t attending p IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ctopic pregnancy
5 Other (specify) in the past 12 months?

1 Yes 2 No Pregnant at time of death Month Day Year been signed by the should be detached Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by 2 No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of 24a. Was an has page 2 autopsy death? Yes 2 X N within 24 hours after death.

To the Funeral Director: After this certific completed filled in by the funeral director, Division of Vital or Attending Physician: 25. Was case referred to medical Certificate: To Be 26. Place of Death (Check only one) examiner? Other: 2 🕱 No 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 N Other (Specify) HOSPICE 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1X Natural injury 5 Pending work' 1 Tes 2 🗌 No Accident Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 - Homicide determined City or Town, State) To the Hospital Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifier 3 X Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 2011

State Registrar

DHMH 17 Rev 7/2009

p.m.

2011

13,

SAUNDERS

BARBARA

JACKIE JONES,

31. Date filed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

CRNP

TIMONIUM, MD 21093

2300 DULANEY VALLEY RD.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Year Physician/ 8:55 Marian Almeda Scott 201 Medical 4c. County of Death 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner Harford Citizens Haure arace Nuvsina 8. Date of Birth (Month, Day, Mar. 10 9. Birthplace (State or Foreign If Under 24 Hrs. Hours Min. If Under 7. Age (In yrs. last birthday) Virginia Virginia S. Social Security Number **Funeral** Months 1 □ M 2 🖾 F Days 77 215-30-5966 Director Usual Residence of Decedent 10d. Inside City Limits ms 23a or 28a-f shov must be notified at 10b. County 10c. City, Town or Location 10a. State filed within 72 hours after death with the Maryland Director 1 Yes 2 No Aberdeen Maryland Harford 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number item 27 is marked other than "natural", or items 23a other traumatic event, the Medical Examiner must be Funeral USA 21001 698 Courtney Drive 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 12. Was Decedent Ever in U.S. 11. Marital Status Armed Forces?
1 ☐ Yes 2 🛣 No Black, White, etc. 1 Never Married 2 Married Completed by Maryland 21215-0036 1 ☐ Yes 2X No 3 X Widowed 4 ☐ Divorced White Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during life. DO NOT use retired) 16b. Kind of Business Industry 15. Decedent's Education during most of working (Specify only highest grade completed) permit. Page 1 and 2 should be filed within 72 Department of Health and Mental Hygiene. Important. If item 27 is marked other than any injury or other traumatic event, the Men Elementary/Seconday (0-12) College (1-4 or 5+) Program Analyst U.S. Government Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) ည Martha Marie Beavers William (nmn) Williamson 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 698 Courtney Drive, Aberdeen, Maryland 21001 Patricia Scott-Badeker/Daughter Baltimore, 20c. Location - City or Town, State 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place, 1 XBurial 2 Cremation 3 Removal from State Harford Memorial Gdn. 4/15/2011 4 ☐ Donation 5 ☐ Other (Specify) Aberdeen, Maryland 22. Name and Address of Facility McComas Funeral Home, P.A. 317 Cokesbury Road, Abingdon, Maryland 21009 Part 1. Enter the disease, or complications that caused shock, or heart failure. List only one cause on each line ise, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Onset and Death Immediate Cause (Final Physician/ Unimi disease or condition Medical resulting in death) Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a nonsequence of) Examine Cause (Disease or iinjury that initiated events resulting in death) Last The law requires that the death certificate be executed attending physician and or use as the burial-tran Due to (or as a consequence of): Physician/Medical Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant Live Birth 2 - Fetal death 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ Year in the past 12 months?

1 Yes 2 No Month Dav Pregnant at time of death page 2 should be detached Records, P.O. 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 1 Yes 2 No 3 Probably 4 Unknown Maria Completed 24b. Were autopsy findings available delylstim 24a. Was an prior to completion of cause of death?

1 Yes 2 No autopsy performed this certificate within 24 hours after death.

To the Funeral Director: After this certific completed filled in by the funeral director, it Hospital or Attending Physician: 25. Was case referred to 26. Place of Death (Check only one) Division of Vital Be examiner? Other: 1 🗌 Yes 2 M No 1 Inpatient 2 ER/Outpatient 3 DOA Nursing Home 5 Residence 6 Other (Specify) မ 28b. Time of 27. Man / r of Death 28a. Date of injury 28c. Injury at 28d. Describe how injury occurred Certificate: (Month, Day, Year) injury Natural 5 Pending 1 ☐ Yes 2 ☐ No Accident Accident Investigation Suicide 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 4 ☐ Homicide determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifie of person who completed cause of death (Item 23a) (Type, Print) 30. Name and address

DHMH 17 Rev 7/2009

State Registrar 31. Date filed (M

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Betty Kreafle Schv	1.	For State	tate of Maryl	and / [Departi Certif	ment of icate of	Health Death	and	Menta	l Hygie		. No.	201	The same of	12	25
Physician		egistrar . Decedent's Name (First, Midd	dle,Last)	_							ite of Death		Year		me of Deat	.h
Medical Examine	er	Betty Krea:			:					Ap	ril 11, 20	11			730 hrs	
	4	4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 10106 Ferguson Road 4c. County of D Baltimore C										-				
Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24Hrs. Months Days Hours Min.							24Hrs. 8. 0	s. 8. Date of Birth(MM/DD/YYYY) 9. Birthplace (State or						
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Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Importact: If item 27 is marked other than "outural", or items 23a or 28a-f sho iojury or other traumatic event, the Medical Examiner must be ootified at once.		20a. Method of Disposition	-uaugiicei		20b. Pla	ace of Dispos	ition (Nam	e of cem	etery,	Da	te	20c. Lo	ocation - City			
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Box 68760, c death certificate by the attending physic ed for use as the but	Physician/Me	IF FEMALE: 23b. Was decedent pregnant i	- 45-	es, outcom	e of pregn		etal death	3 [Ectopic	pregnancy		1	Month	Day		Year
x 68 h certij lending use as	iciar	past 12 months?	4 Pro		time of dea	=	other (Spe	cify)								
Bo; te deatl the att	hys	1 Yes 2 ✓ No 9 Part II. Other significant cor		nknown	but not re	eulting in the	underlying	cause o	iven in Pa	rt I.	23e. Did t	obacco u	use contribute	e to the	cause of c	leath?
P.O.	by P	Part II. Other significant cor	iditions contributin	ig to death	DULTION	Sulling in the	andonying	02200 8	,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	33	1 Ye	s 2 _	No 3	Probabl	y 4 🗹 U	Inknown
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To To To Com	Med	29b. Signature and title of ce		and manner stated. 29c. License number								29d.	Date signed	(Month	, Day, Year	r)
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		Theodore M. King,			fedical E	Examiner	111 P	enn S	ireet, Ba	aitirnore,	MD 2120					
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11-02784 Adam Glenn Tho	mps	Please Type or Print in Black Indelible Ink. En State of Maryland / Department of Health	sure All Copies and Mental Hy	s Are Legib giene	ole. 201	1 1225				
Physicia	R	- For State Certificate of Death tegistrar 1. Decedent's Name (First, Middle, Last)		Reg. N	No.	3. Time of Death				
Medical Examin	ier	Adam Glenn Thompson	wn, or Location of Death	Month Da April 12, 201	1 4c. County of Deatl	0122 hrs				
Funeral Director		3303 Conowingo Road Street 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under Months 1 \(\begin{align*}		_	Forei	rthplace (State or gn puntry) MD				
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Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Heath and Mental Hygiers we "seatural", or items 23a or 28a-f she important: If item 77 is marked other than "seatural", or items 23a or 28a-f she iojury or other traumatic evect, the Medical Examiner must be sotified at occ.	Funeral	11. Marital Status 1 X Never Married 2 Married Armed Forces? 1 Yes 2 X No		USA nic Origin? (Specify Yes or No- exican, Puerto Rican, etc.) pecify: USA 14. Race - American Indian, Bl White, etc. Specify: White						
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21215-0036 Motta Hygiene. marked other thro	To Be Com	17. Father's Name (First, Middle, Last) Roy Glenn Thompson 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address		e (First, Middle, Ma a Ann Han Rural Route Numbe	tman	te, Zip Code)				
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Baltimore, permit. Pages 1 a Department of He Important: If ite iojury or other ti		21. Signature of the last convice Electrical	Address of Facility Sch	nimunek F	uneral Ho	me of BelAir				
Physician Medical aminer	Examiner	failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause c.				Between Onset and Death				
y se executed cian and rrial - transit	न									
Box 68760, e death certificate be exe the attending physician. ed for use as the burial -	siclar	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 4 Pregnant at time of death 5 Other (Special Control of the control of	ecify)		23d. Date of deliv	Day Year				
Division of Vital Records, P.O. Box 68760, To the Hospital or Atteoding Physician: The law requires that the death certificate be ex within 24 hours after death. To the Funcarial Director: After this certificate has been signed by the attending physician To the Funcarial Director: After this certificate has been signed by the attending physician to the funcarial director man 2, should be detached for use as the burial	leted by Ph		g cause given in Part I.	1 Yes 24a. Was a autops	2 No 3 F	to the cause of death? Probably 4 Unknown autopsy findings available to completion of cause of				
ial Reco	Be Completed	25. Was case referred to medical	26.Place of Death (Chec		med? death 2 No 1 ✓	Yes 2 No				
Division of Vital Is the Hospital or Atteoding Physician: hin 24 hours after death. The Ruser After this certification is the studies of the control of the	tion: To	1 Ves 2 No Impatient 2 Erocotpation 3 27 Manner of Death 28a, Date of Injury 28b. Time of Injury	28c. Injury at Work? 1 Yes 2 ✓ No	28d. Describe h Subject drive	ow injury occurred er in single vehi	cle collision				
Division Tospital or Atteod 4 hours after death. Tuestal Director:	I Certification:	2 Accident Investigation 3 Suicide 6 Could not be determined (Specify) Major Road / Highway 28e. Place of Injury - At home, farm, street, factory, office building, etc. 28f. Location (Street and Number or Rural Route Number or Town, State) 3 3 Suicide 6 Could not be determined (Specify) Major Road / Highway 28e. Place of Injury - At home, farm, street, factory, office building, etc. 28f. Location (Street and Number or Rural Route Number or Town, State) 3303 Conowingo Road, Street, MD								
To the Hospital within 24 hours To the Ruocral	Medical	(Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in one and manner stated. 29b. Signature and title of certifier	9c. License number O.C.M.E.	d at the time, date	29d. Date signed April 12, 2011	(Month, Day, Year)				
<i>n</i> ₂ √		30. Name and address of person with completed cause of death (Item 23a) Melissa Brassell, MD Assistant Medical Examiner 111 Penn S	Street, Baltimore, M	ID 21201						
	Stat istra)	_						
DHMH 17 Rev	1/200	1 OCAME ORIGINAL								

Please Type or Print in Black Indelible Ink Fasure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registra Certificate of Death Rea. No. 3. Time of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day **Physician** 1210 2011 11 Iracei AP211 /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner ALTIMORE AGNES HOIPITAL 8. Date of Birti 9-28-1958 9. Birthplace (State or Foreign (Month, Day, Year) If Under 24 Hrs. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** Days Min Months 1 □ M 2 🔀 F 53 215-46-4365 Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10b. County 10a. State 28a-f show traumatic event, the Medical Examiner must be notified at 1 Yes 2 No Director Montgomeru 10g. Citizen of What Country? 10e. Street and Number ō 0000 23a USP Whitmoor lerrace Funeral 14. Race - American Indian, Black, White, etc. items Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status 72 hours after 1 Nes 2 X If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 o, 1 ☐ Yes 2 No Specify: Specify þ 3 ☐ Widowed 4 M Divorced white "natural" Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) filed within 7 I Hygiene. is marked other than Elementary/Secondary (0-12) College (1-4or 5+) Education Teacher 79 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) 2 should be fi races race 19h Mailing Address (Street and Number of Bura Route Number City or Town, State 7in Code)

13/04 Lockdale Rd. Silver Spring, Md 20906

233

Be of Disposition (Name of Date 2000 Location - City or Town, State) 19a. Informant's Name/Relationship (Type Print)

Juliette Goldman/Sister

20a. Method of Disposition permit. Pages 1 and 2 s
Department of Health ar
Important: If item 27 is
any Injury or other trau Pages 1 and 2 20c. Location - City or Town, 20b. Place of Disposition (Name of cemetery, crematory or other Date VWK 1 ☐ Burial 2 XCremation 3 ☐ Removal from State 4 Donation 5 ☐ Other (Specify)

21. Signature Fun ral Service Line rematou reenwood 22. Name and Address of mility Appr imate Interval Between Onset and Death Ther the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, or heart failure. List only one cause on each line. 23a. Pakti shock Immedi te Cause (Final disea or condition resulting in death) KESTIPATORS FAILURE Physician CEAG /Medical Due to (or as a consequence of) Examiner CARCINOMATORIS MONTH FRITONEAL if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) certificate be executed attending physician and for use as the burial-transit Due to (or as a consequence of): P.O. Box 68760. Physician/Medical IF FEMALE: yes, outcome of pregnancy
☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? ☐ Pregnant at time of death 5 Other (specify) cate has been signed by the a page 2 should be detached in 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records. \$ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🔻 nknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed) certificate l 2 No 1 ☐ Yes 2 No 1 ☐ Yes 25. Was case referred to medical examiner? funeral director, 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Minpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To After this Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death 5 Pending investigation 1 Natural 2 ☐ Accident 1 ☐ Yes 2 ☐ No after death. Director: filled in by the 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide within 24 hours a 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier r 20 2011 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 900 BALTIMORE 2. ANTON 32. Registrar's Signature 31. Date filed (Month, Day, Year) State Registrar DHMH 17 Rev 1/2001

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Tyson-owens 721 AM 2011 Medical AOVI 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death BON SECOUS Baltimore Baltimore Baltimue Health Social Security Number Year If Under 24 Hrs. Birthplace (State or Foreign Country) Age (In yrs. last birthday) 8. Date of Birth **Funeral** 1 □ M 2 🗹 F Month, Day, 214-78-3983 Months Hours Min. Year Director Usual Residence of Decedent iral", or items 23a or 28a-f show Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 No MOY 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. "natural", or 1 Never Married 2 Married ξ Baltimore, Maryland 21215-0036 1 Yes 2 No Completed 3 Widowed 4 Divorced Year or Dates injury or other traumatic event, the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation
(Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) marked other than conday (0-12) College (1-4 or 5+) urso Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) and Mental ည should be 19a. Informant's Name/Relationship Type, Print) (Daug hter) permit. Page 1 and 2 shou Department of Health and Important: If item 27 is m 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date 1 Burial 2 Cremation 3 Removal from State cemetery, crematory or other place 4 Donation 5 Other (Specify) 22. Name and Address of Facility Signature of Funeral Service Licensee 3 RN 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ Myocardi disease or condition Medical resulting in death) Due to (of as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Examine Due to (or as a consequence of): attending physician and for use as the burial-transit or Attending Physician: The law requires that the death certificate be executed resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant in the past 12 months?
1 ☐ Yes 2 ☑ No 23d. Date of delivery Live Birth 2 Fetal death 3 Ectopic pregnancy 5 Other (specify) ____ Day Pregnant at time of death Month Year s been signed by the s 1 ☐ Yes 2 Ⅲ 9 ☐ Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 2 No 1 Tes 3 Probably 4 Unknown has been 24b. Were autopsy findings available prior to completion of cause of 24a, Was an autopsy page performe death? within 24 hours after death.

To the Funeral Director: After this certificate I completed filled in by the funeral director, page 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? 1 Yes ဂ္ 2 NO 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Deatl 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending injury work? 2 🗌 No Accident Investigation 3 Suicide 4 Homicide Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number City or Town, State Hospital Medical 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 3 only one) the 29b. Signature and title of certifie 2 29c. License numbe 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Sherron Secours Thompson Bens HOS 1 5 201 32. Registrar's Signature State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month Physician/ 2011 P_{\bullet}^{M} 10:02 April <u>Frederick H. Tarburton,</u> Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death **Examiner** Baltimore Towson Gilchrist Hospice 9. Birthplace (State or Foreign Country) Maryland 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) June 9, 1 Social Security Number **Funeral** Days 1 🕅 M 2 🗆 F Months Hours 1933 Director 218-28-6814 28a-f shov 10d. Inside City Limits 10b. County 10c. City, Town or Location rral", or items 23a or 28a-f sho Examiner must be notified at 10a State Director 1 🗌 Yes 2 😾 No Maryland Edgemere Baltimore 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number Funeral United States 21219 7811 North Cove Road Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. 11. Marital Status 1 Never Married 2 Married 1 X Yes 2 If Yes, Give Year or Dates þ 2 No Baltimore, Maryland 21215-0036 permit. Page 1 and 2 should be filed within 72 hours aft Department of Health and Mental Hygiers. Important: If item 27 is marked other than "natural", any injury or other traumatic event, the Medical Exanonce. 1 Yes 2 No Specify: Specify: White 3 X Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b, Kind of Business Industry Elementary/Seconday (0-12) College (1-4 or 5+) General Motors Auto Manufacturing Manufacturing 9 Years Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) မ Frances Nagangast Emerson Tarburton, Sr. 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Edgemere, Maryland 21219 7811 North Cove Road (Daughter) Anita Raab 20c. Location - City or Town, State 20a. Method of Disposition 20b. Place of Disposition (Name of Date cemetery, crematory or other place) 1X Burial 2 ☐ Cremation 3 ☐ Removal from State 4/14/2011 Baltimore, Maryland Oak Lawn Cemetery 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility
Duda-Ruck Funeral Home of Dundalk, Inc. 21. Signature of Funeral Service Licenses Dundalk, Maryland Wise Avenue Part 1. Enter the disease of complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure cust only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final holic L120 Physician/ 100 Ters disease or condition Medical resulting in death) Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to in mediate cause. Enter Underlying Cause (Disease or linjury that initiated events Examiner Daw to (or as a consequence of): attending physician and for use as the burial-transit the Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of): resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ signed by the atter in the past 12 months? Month Day Pregnant at time of death 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 2 100 3 Probably 4 Unknown 1 Yes within 24 hours after death.

To the Funeral Director. After this certificate has been si completed filled in by the funeral director, page 2 should I 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed Yes 2 25. Was case referred to medical 26. Place of Death (Check only one) To Be examiner? Other: 4 Nursing Home 5 Residence 6 XOther (Specify) 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28c. Injury at work? 1 ☐ Yes 2 ☐ No 28b. Time of 28d. Describe how injury occurred Certificate: Natural 5 Pending Accident
Suicide Investigation Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Medical ertifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check 3 🗀 29b. Signature and title of certifier 29c. License number 29d, Date signed (Month, Day, Year) 2011

State Registrar

LIXIV

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

31. Date filed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death Reg. No: 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month 2011 1:30 AM April Don Andrew Waite Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Montgomery Rockville Casey House If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign 6. Sex 8. Date of Birth Social Security Number 7. Age (In vrs. last birthday) Funeral Days Hours May 17 1 🛛 M 2 🗆 F Months Min Year 929 Virginia Yrs Director 577-32-5980 81 Usual Residence of Decedent or 28a-f show notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 72 hours after death with the Maryland Director 1 X Yes 2 □ No Rockville Montgomery <u>Maryland</u> ō 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? items 23a or ner must be n Funeral United States 20850 303 Adclare Road Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian er than "natural", or iter the Medical Examiner rmed Forces?

Yes 2 \sum No Black, White, etc. 1 Never Married 2 Married ģ Maryland 21215-0036 If Yes, Give Year or Dates:1946-1948 1 ☐ Yes 2 X No Specify. Specify: Completed 3 Widowed 4 Divorced White 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) should be filed within 72 h and Mental Hygiene. 7 is marked other than "r Elementary/Seconday (0-12) College (1-4 or 5+) 4 Car Dealer Manager traumatic event, Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ၉ permit. Page 1 and 2 should be Department of Health and Men Important: If item 27 is marke any injury or other traumatic. once. Don Andrew Waite Katherine Hall 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1405 Thorndon Dr. Bel Air, MD 21015 Don A. Waite / Son/POA Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place) 1 Burial 2 X Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Journey Crematory 4/14/2011 Woodbine, Maryland Flinal 22. Name and Address of Facility Going Home Cremation Service P.O. Box 784 Beverly L. Heckrotte, P.A. Clarksville, M 21. Signature of Funeral Service Lic 21029 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Onset and Death Immediate Cause (Final Physician/ Anoxic Encephalopathy disease or condition Medical resulting in death) Examiner Due to (or as a consequence of) Sepsis Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury that in the cause or linguistics of the cause of the Due to (or as a consequence of): sician and burial-transit Exami Urinary Tract Infection that initiated events resulting in death) Last Due to (or as a consequence of): attending physician for use as the buria Physician/Medical requires that the death certificate be P.O. Box 68760 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4 Pregnant : 9 Unknown Pregnant at time of death 5 Other (specify) signed by the a 1 ☐ Yes 2 L 9 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by √ Division of Vital Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 💆 Unknown should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an Hospital or Attending Physician: The law 124 hours after death.
 Funeral Director: After this certificate has b. page 2 Yes 2 X No 2 No 1 Yes within 24 hours after death.

To the Funeral Director: After this certific completed filled in by the funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: ည 1 🗌 Yes 2 🔀 No 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 X Other (Specify) Hospice 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at work? 1 □ Yes 2 □ No 28d. Describe how injury occurred injury XNatural 5 Pending Investigation Accident 6 Could not be 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 1 💆 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year)

State

Registrar
DHMH 17 Rev 7/2009

Muncaster Mill Road Rockville, MD 20855

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

6001

Joseph

15

D0060634

April 10, 2011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend #19a Per FH G914 4/19/2011 JH State of Maryland / Department of Health and Mental Hygiene 1 - State Certificate of Death Reg. No. Registrar 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month 0:10 AM Leroy M. West. Sr Medical Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Balto. Towson Year If Under 24 Hrs. 8. Date of Birth (Month, Day April 7 Social Security 6. Sex 1 X M 2 □ F If Under 1 9. Birthplace (State or Foreign Numbe 7. Age (In vrs. last birthday **Funeral** Months Days Min Hours ,1943 Mary Land 218-40-8696 68 Yrs Director Usual Residence of Decedent 28a-f show 10a. State 10b. County with the Maryland must be notified at 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes X No Md. Balto. Parkville 10e. Street and Number ò 10f. Zip Code 10g. Citizen of What Country? Funeral items 23a 3311 Delpha Court 21234 USA be filed within 72 hours after death 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, the Medical Examiner Armed Forces?

1 Yes 2 No
If Yes, Give
Year or Dates. 1 Never Married 2 Married Black, White, etc. 5 þ Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify. "natural", Specify: Completed 3 Divorced White 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) and Mental Hygiene. is marked other than Elementary/Seconday (0-12) College (1-4 or 5+) Superintendant Concrete Construction 8th event, Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) permit. Page 1 and 2 should be fi Department of Health and Menta Important: If item 27 is marked any injury or other traumatic ev ဂ္ Willie D. West, Sr. Margaret Baldwin 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Dolores N. West 3311 Delpha Court Spouse Parkville, Md. 21234 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date 1X Burial 2 Cremation 3 Removal from State cemetery, crematory or other place, Holly Hills 4-18-2011 4 Donation 5 Other (Specify) Middle River, Md. 21. Signature of Funeral Service Licenses Schimunek Funeral Home 22. Name and Address of Facility 9705 Belair Road Nottingham, Md. 21236 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Betweer Immediate Cause (Final Onset and Death Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events resulting in death) Last Examine Due to (or as a consequence of) the burial-transit and Due to (or as a consequence of): attending physician Physician/Medical To the Hospital or Attending Physician: The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 use as 1 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) ____ in the past 12 months?

1 Yes 2 No for Month Day Year signed by the at d be detached for Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 X Yes 2 □ No 3 □ Probably 4 □ Unknown Completed plnous peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an within 24 hours after death.

To the Funeral Director: After this certificate has page 2 autopsy performed Yes 2 2 **N**0 1 🗌 Yes funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No ၉ 1 Npatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) Manner of Death Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 2 Accident 5 Pending work?
1 Yes 2 No Investigation filled in by the 3 Suicide 4 Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 1 💢 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 🗆 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 30 Name and address of person who completed cause of death (Item 23a) (Type, Print) 10 State egistrar's Signatu

DHMH 17 Rev 7/2009

Registrar

Baltimore, Maryland 21215-0036 Division of Vital Records, P.O. Box 68760,

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		For		S	tate of M	aryland				ealth and	Mental Hy	giene	ווחס	122	57
		1 - State Registrar	/Fi-+ 0.0i-1-11	- (4)			Ce	rtificat	e of L	eath	T 0. Date of Dr	Reg. No.	- 0 1 1	3. Time of	Dooth
Physicia	an	1. Decedent's Name	ENE	e, Last)			MA	.00-	2 · . i . \	Sidi	2. Date of De Month	Day		943	
/Medic		4a. Facility Name (If		, give street	and number)		VVF	4b. City	, Town, or	Location of Death	APRIL		County of Deat		
Examin	er	The Johns I	Hopkins	s Hosp	ital			Balti	more	City			N/	'A	
Funeral		5. Social Security Nu		6. Sex 1 X M	7. Ag		ast birthday)		r 1 Year	If Under 24 Hrs. Hours Min.	8. Date of Bi	rth ay, Year)	9. Bir Co	hplace (State o	
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filed within 72 hours after death with the Maryland Hygiene. rther than "natural", or items 23a or 28a-f show int, the Medical Examiner must be notified at	Funeral	11. Marital Status 1 Never Marrie	ed 2 Marr	ied 1	Vas Decedent Armed Forces? X Yes 2 —). [13.			spanic Origin? (S n, Mexican, Puert	o Rican, etc.)	,-	Black, Whit		
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s 1 and 2 should be filed within 72 hours after dea if Health and Mental Hygiene. Item 27 is marked other than "natural", or items other traumatic event, the Medical Examiner mu		19a. Informant's Nar	me/Relations	hip (Type. F	rint)		19b. Mail	ing Addres	ss (Street a	and Number or R	ural Route Num	ber, City o	r Town, State,	Zip Code)	
and and and and and and and and and and		RONALD I		YNSK	/ SON					STREET,					1231
permit. Pages 1 and 2 Department of Health a Important: If item 27 is any injury or other tra		20a. Method of Dispo 1 Burial 2 □	Cremation		val from State	C	lace of Disp emetery, cre	matory or	other place		Date		cation - City or		
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tificate be executed g physician and as the burial-transit	lical														
rtifica ng ph e as th	Physician/Medic	IF FEMALE:													
death certifi attending p	cian,	23b. Was decedent in the past 12 n		1	yes, outcome Live birth Pregnant a	2 Fetal	death 3	_ Ectopic				4	23d. Date of de Month	livery Day	Year
the a	ysic	1 Yes 2 9 Unknown	No		Unknown	t time of de	aui 5	Other (s	pecity)						
The law requires that the death certificate be executed ate has been signed by the attending physician and page 2 should be detached for use as the burial-transi	by PI	Part II. Other signific	cant condition	ons contribu	iting to death b	out not resu	ulting in the	underlying	g cause giv	ren in Part I.	23e. Did	tobacco ι	use contribute t	o the cause of	death?
quires n sign ruld be											1 🗆	Yes 2	□No 3□P	robably 4	Unknown
aw rec s bee 2 sho	Completed										24a. Was		prior to	utopsy findings completion of	available cause of
stcian: The lar certificate has irector, page 2	Com										perf	ormed? 2 No	death?	2 No	
yslcian: s certifica director,	Be	25. Was case referre examiner?		Hosp	ital:				Othe	26. Place of Dea	th (Check only	one)			
Physic this o	6	1 Yes 2 □ N 27. Manner of Death			a. Date of Inju		R/Outpatie 28b. Time of		OA Ouro	4 L Nursing H	ome 5 Res			cify)	
ding th. After s fune	tion	1 Natural 2 Accident	5 Pendin investiç	g	(Month, Da	Year)	Injury	М	Work			Solide flow injury occurred			
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To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certific completely filled in by the funeral director.	Medical			Examiner:		f examinati				ne, date and place pinion, death occ					(s)
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35		30. Name and addr	es of person	-	eted cause of	1.	23a) (Type		100	_	M = at 221	- 14 - 5			0400=
Sta	te	31. Date filed (Mone)		ran	32. legistra	ar's Signatu	Ire —			600	North W	oite S	t, Baltim	ore, MD,	21287
Registr		A	PR 15	2011	Den	NA	9. 40	ale	,						

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 06:55 Betty Jean Woznicki 2011 A^{M} Apri Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Baltimore Greater Baltimore Medical Centler Towson 2201-24#5206 7. Age (In vrs. last birthday) If Under 1 Year If Under 24 Hrs 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Months Days Hours 1270571927 Mary land 169-14-6922 83 Director Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits with the Maryland must be notified at Director 28a-f Maryland Baltimore 1 Yes 2XXNo Essex 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? ō 23a Funeral 42 Clipper Road 21221 U.S.A. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-12. Was Decedent Ever in U.S. 11. Marital Status 14 Race - American Indian. Armed Forces? Yes, specify Cuban, Mexican, Puerto Rican, etc.) þ 1 Never Married 2 Married If Yes, Give Year or Dates 1 Yes 2XXNo Specify: Specify: White Completed 3 X Widowed 4 Divorced filed within 72 hours 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Maryland 2121 Elementary/Seconday (0-12) College (1-4 or 5+) permit. Page 1 and 2 should be filed with Department of Health and Mental Hygiens Important: If item 27 is marked other than yinjury or other trainment. Homemaker Own Home Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Erik Anderson Gertrude Henderson 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Edward J. Woznicki (Son) 13726 Manda Mill Lane, Phoenix, Maryland 21131 Baltimore, I 20b. Place of Disposition (Name of 20a. Method of Disposition 20c. Location - City or Town, State Date 1 Burial 2XXCremation 3 Removal from State Bayview Crematory, Inc. 04/15/2011 Baltimore, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21 Ston ture of Funeral Section License 22. Name and Address of Facility Bruzdziński Funeral Home, P.A. 1407 Old Eastern Avenue, Essex, Maryland 21221 23a. P . Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, snock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death mmediate Cause (Final Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner PETERUCTION Sub to (or as a consoquence of): Sequentially list conditions Examine ri any, leading to immediate cause. Enter Underlying Cause (Disease or linjury physician and the burial-transit that initiated events Due to (or as a consequence of) resulting in death) Last Physician/Medical the Hospital or Attending Physician: The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 signed by the attending p IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy 5 Other (specify) in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day Year Pregnant at time of death 9 Unknown Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by ATPIAL FLORINATIO, CAPONIC PENAL INSUFFICIENCY, 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? Congestive yeart Failure 24a. Was an has e 2 autopsy performed? 1 ☐ Yes 2 ☐ No 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Hospital 1 Yes 2 No Other: ည 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify) eral Director: After th 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 Natural injury work? 1 ☐ Yes 2 ☐ No 5 Pending Accident Investigation 3 ☐ Suicide 4 ☐ Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) 24 hours Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifier 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 31. Date filed (Month, Day, Year) State

DHMH 17 Rev 7/2009

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene-For State Registrar Certificate of Death Reg. No 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ April 2ď¶1 12:50 Wolf Dolores Martha Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Baltimore 1224 Maple Avenue Arbutus 5. Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) **Funeral** 1 □ M 2 🗓 F April 5,1925 Months Days Hours Min Country) Maryland Director 219-16-5995 86 Usual Residence of Decedent 28a-f shov 10a. State 10b. County Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits Director 1 ☐ Yes 2 😿 No MD Baltimore Arbutus 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? items 23a or Funeral with 21227 IISA 1224 Maple Avenue 72 hours after death 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14. Race - American Indian. 11. Marital Status Armed Forces?
1 ☐ Yes 2 XXNo If Yes, specify Cuban, Mexican, Puerto Rican, etc. Black, White, etc. ò Completed by 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 Yes 2 XNo Specify: If Yes, Give Year or Dates and Mental Hygiene. is marked other than "natural", Specify: 3 X Widowed 4 Divorced White traumatic event, the Medical Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business Industry Elementary/Seconday (0-12) College (1-4 or 5+) 10 Homemaker Own Home Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Mary B Strumsky Henry J. Yienger permit. Page 1 and 2 should be Department of Health and Men Important: If item 27 is marke any injury or other traumatic 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1224 Maple Avenue, Arbutus Maryland 21227 Harriet T. Cossio-Daughter 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 1 XBurial 2 Cremation 3 Removal from State New Cathedral Cemetery 4-15-2011 Baltimore Maryland 4 Donation 5 Other (Specify) 22. Name and Address of Facility Ambrose Funeral Home Inc Signature of Funeral Service icens 1328 Sulphur Spring Road Arbutus Maryland 21227 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Betwee shock, or heart failure. List only one cause on each line Immediate Cause (Final Onset and Death Physician/ Congestive heart disease or condition resulting in death) Medical Due to r as a consequence of) Examiner Sequentially list conditions, Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury attending physician and a for use as the burial-transit or Attending Physician: The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Pregnant at time of death 5 Other (specify) 2 🗌 No the detached 9 Unknown g 🗌 Unknown sate has been signed by page 2 should be detach Part II. Qther significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24a. Was an 24b. Were autopsy findings available prior to completion of cause of Chrma certificate has autopsy performe death? 1 ☐ Yes 2 ☐ No director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital: Other: 2 No မ To the Hospital or Attending Physical within 24 hours after death.

To the Funeral Director: After this completed filled in by the funeral director. 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) this 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred 5 \square Pending 1 Natural 1 \sum Yes Accident Investigation 6 Could not be Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 25861 April 13, 2011 mo

Registrar

State

Bruce R. McCurdy, MD. 716 Maiden Choice Lane Baltimore, Maryland 21228

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

31. Date filed (Month, Day, Year) APR 1 5 2011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene? State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) Date of Death Physician/ Betty Jo Wilson Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Anne Arundel Baltimore-Washington Medical Center Glen Burnie 9. Birthplace (State or Foreign Country) West Virginia Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth Month, Day, **Funeral** 1 ☐ M 2 🔀 F Director 232-46-8402 80 Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho any injury or other traumatic event, the Medical Examiner must be notified at Director 1 X Yes 2 No Marvland Anne Arundel Odenton 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Completed by Funeral 1208 Odenton Road, Apt. 401 21113 U.S.A. 12. Was Decedent Ever in U.S. Armed Forces?
1 Yes 2 No
If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 🛣 No Specify: White 3 XWidowed 4 ☐ Divorced Year or Dates 16a. Decedent's Usual Occupation 16b. Kind of Business Industry 15. Decedent's Education (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Baltimore, Maryland 2121 Elementary/Seconday (0-12) College (1-4 or 5+) and Mental Hygiene. is marked other tha Homemaker Own Home permit. Page 1 and 2 should be filed verpeartment of Health and Mental Hygemportant: If item 27 is marked oth Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Branson Holbert Hallie Lewis 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3627 Plum Street, Parkersburg, West Virginia 26104 Richard Wilson / Son 20b. Place of Disposition (Name of cemetery, crematory or other place)
Ward-Wilson Cemetery 20a. Method of Disposition 20c. Location - City or Town, State Pleasant Hill, 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 4-14-11 4 ☐ Donation 5 ☐ Other (Specify) West Virginia . Signature of Funeral Service Licensee 22. Name and Address of Facility Marzullo Funeral Chapel, P.A. 6009 Harford Road, Baltimore, Maryland 21214 michau 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions, Examiner Due to for as a conscionne of If any, leading to Immediate cause. Enter Underlying Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or iinjury as the bunal-tran that initiated events Due to (or as a consequence of): ttending physician Be Completed by Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: use 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant Ectopic pregnancy in the past 12 months? Month Day Year 5 Other (specify) Pregnant at time of death 2 No the 9 Unknown 9 Unknown cate has been signed by page 2 should be detact Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 No 3 Probably 4 Unknown 1 🗌 Yes 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performe 2 🖪 No After this certificate 1 🗌 Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) the funeral director, Other: 4 Nursing Home 5 Residence 6 Other (Specify, Hospital: 2 No မှ 1 D Inpatient 2 ER/Outpatient 3 DOA 27. Mani of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 5 Pending work? 1 ☐ Yes 2 ☐ No Natural Accident Investigation within 24 hours after death

To the Funeral Director: A

completed filled in by the 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) filed (Month, Day, Year)
APR 15 201 32. Registrar's State Registrar

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygieney Certificate of Death Registrar Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month , TI Physician/ George W. Yutzy, Sr M Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Days Hours Min. 1 🛛 M 2 🗆 F Jully 19, 1921 Pennsylvania 174-16-2868 Director 89 Usual Residence of Decedent shov at 10a. State 10c. City, Town or Location 10d. Inside City Limits Director must be notified 28a-f MD Baltimore Glen Arm 1 Yes 2 No ō 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 23aFuneral 21057 4315 Conifer Court USA items 12. Was Decedent Ever in U.S. Armed Forces?

1X Yes 2 □ No
If Yes, Give 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. "natural", or iter idical Examiner .0. þ 1 Never Married 2 X Married within 72 hours after Maryland 21215-0036 1 Yes 2 XNo Specify: Specify: white 3 Divorced 4 Divorced Completed Year or Dates the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) should be filed within 72 h and Mental Hygiene. 7 is marked other than "r Elementary/Seconday (0-12) Haverhill Construction College (1-4 or 5+) 12 President/CEO Company Inc Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Bertha M. Crise Norman R. Yutzy 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 4315 Conifer Court-Glen Arm, Maryland 21057 Department of Health an Important: If item 27 is any injury or any Joan Yutzy-spouse Baltimore, 20a, Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 1 🔀 Burial 2 🗆 Cremation 3 🗆 Removal from State Parkville, Maryland Parkwood Cemetery Apr.16,2011 4 Donation 5 Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Evans Funeral Chapel and Cremation Ser. 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury Due to (or as a consequence of): and tran that initiated events Due to (or as a consequence of): resulting in death) Last burialattending physician for use as the buria Medical certificate be Box 68760 IF FFMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death Physician/ 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months? Month Day Year 4 Pregnant a
9 Unknown Pregnant at time of death 1 Yes 2 No ed by the a detached f P.0. signed to Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ of Vital Records, 2 No 1 🗌 Yes 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a. Was an has page 2 s autopsy certificate 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) ည After this of funeral direction 1 Inpatient 2 ER/Outpatient 3 DOA To the Hospital or Attending P. within 24 hours after death.
To the Funeral Director; After the completed filled in by the funera 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred Watural 5 Pending Division 1 Yes 2 🗌 No 2 Accident
3 Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 31. Date filed (Month, Day, Year) 32. Registrar's Signature State 5 Registrar

11-02473 Joseph Altman Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

			ntment of Health and Mental H tificate of Death	Reg. No.	011 12202
Physicia Medical Exami	ın/	1. Decedent's Name (First, Middle,Last)		2. Date of Death Month Day March 31, 2011	3. Time of Death Year 1045 hrs
MEGICAI EXAMIN	iei	Joseph Neale Altman 4a. Facility Name (if not institution, give street end number)	4b. City, Town, or Location of Death		unty of Death
<i>3</i>		University Hospital	Baltimore		altimore
Funeral Director		5. Social Security Number 6. Sex 7. Age (In yrs. la 180-62-0095 1 M 2 F 33	sst birthday) If Under 1 Year If Under 24Hr. Months Days Hours Mir Yrs.		77 9. Birthplace (State or Poreign Dist. of Country Columbia
nd how any cc.			Town or Location 1 timore	-	10d. Inside City Limits 1 X Yes 2 No
death with the Maryland or items 23s or 28s-f sho must be notified at once.	Director	10e. Street and Number	10f. Zip Code	10g. Citizen	of What Country?
th the 1		509 McCabe Ave.	21212	USA	
ath wi	Funeral	11. Marital Status 1 XNever Married 2 Married Armed Forces?	S. 13. Was Decedent of Hispanic Origin? (S If Yes, specify Cuban, Mexican, Puerto		Race - American Indian, Black, White, etc.
after de	by Fu	3 Widowed 4 Divorced If Yes, Give Year or Dates:	1 Yes 2 XX No specify:	Spec	city: White
hours in aturi	8	15. Decedent's Education (Specify only highest grade completed)	16a. Decedent's Usual Occupation (Give kind of during most of working life. DO NOT use ret		of Business/Industry
hin 72 the re-	Completed	Elementary/Secondary (0-12) College (1-4 or 5+) 5+	attorney	l law	firm
5-00 led will Hygien other		17. Father's Name (First, Middle, Last)	18.Mother's Nam	e (First, Middle, Maiden Surn	name)
21215-0036 uld be filed within 7 Mental Hygiene. marked other than c event, the Medical	To Be	Richard S. Altman, Jr. 19a. Informant's Name/Relationship (Type, Print)	Debora 19b. Mailing Address (Street and Number or	ah Pelet Rural Route Number, City or	Town, State, Zip Code)
Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28s-f she injury or other traumatic event, the Medical Examiner, must be notified at once		Richard S. Altman, Jr.	507 Scrimshaw Way, S	THE COLUMN TWO IS NOT THE COLUMN TWO IS NOT	
Baltimore, MD semit. Pages I and 2 sho Department of Health and Important: If item 27 is injury or other traumati	Ī		Place of Disposition (Name of cemetery, rematory or other place)	Date 20c. Loca	ition - City or Town, State
Pager ment o		4 Donation 5 Other Specify: St.	Joseph New Cath. Cem. Apr	r. 6,2011 Baus	man, PA 17504
Balt permit Depart Impor		21. Signature of Funeral Service Licensee	22. Name and Address of Facility Char 414 E. King St., Land	rles F. Snyder Fi	uneral Home & Cremato
Physician	+	23a. Part I. Enter the disease, or complications that caused the death. failure, List only one cause on each line.			or heart Approximate Interval Between Onset and
/Medical		Immediate Cause (Final disease a. Multiple Injuries			Death
		or condition resulting in death) Due to (or as a consequence of) b.	¢		
	ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause): -		
	xam	(Disease or injury that initiated events resulting in death) Last):		
cecuted	E E	d			
68760, certificate be executed nding physician and se as the burial - transit	Aedical Examiner	IF FEMALE: 23c. If yes, outcome of pregn	ancy	23d Da	ate of delivery
cath certificat eath certificat attending phyfor use as the	ian/N	23b. Was decedent pregnant in the past 12 months?	2 Fetal death 3 Ectopic pregn		
	Physician/N	4 Pregnant at time of dea	5 Other (Specify)		
cords, P.O. Box law requires that the death has been signed by the atte	by Ph	Part il. Other significant conditions contributing to death but not re-	sulting in the underlying cause given in Part I.		contribute to the cause of death?
rds, P	Ba	-		1 Yes 2 No	3 Probably 4 Unknown 24b. Were autopsy findings available
cord law rec has be	Completed			autopsy perform <u>ed</u> ?	prior to completion of cause of death?
tal Rection: The certificate ector, page		25. Was case referred to medical	26.Place of Death (Check	1 Yes 2 No	1 Yes 2 No
g i Sig	o Be	examiner?	Othor	ng Home 5 Residence	6 Other:
of Jing Ph	Ë	27. Manner of Death 28a. Date of Injury (Month, Day, Year)	28b. Time of Injury 28c. Injury at Work?	28d. Describe how injury of Subject jumped in fro	
	Cati	2 Accident Investigation	me, farm, street, factory, office building, etc.	28f Location (Street and N	lumber or Rural Route Number, City
Divi	Certification:	3 ✓ Suicide 6 Could not be determined (Specify) Local Street		or Town, State) 1000 block Light Street,	
Division To the Hospital or Attentum 14 hours after death within 24 hours after death To the Funeral Director:		29a. Certifier 1 Certifying Physician: To the best of my knowledge	e, death occurred at the time, date and place, and	d due to the cause(s) and ma	anner as stated.
To the within To the compl	Medical	one) 2 Medical Examiner: On the basis of examination an and manner stated. 29b. Signature and title of certifier	d/or investigation, in my opinion, death occurred		and due to the cause(s)
		411111	O.C.M.E.	April 1,	
	ŀ	30. Name and address of person who completed cause of death (Item 2	23a)		
		Zabiullah Ali, M.D. Assistant Medical Examiner	111 Penn Street, Baltimore, MD 21	1201	
Sta	ate rar	31. Date filed (Month, Day, Year) 32. Refisard's Signatur	A Barles		

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Brown Richard **Physician** 22:23 March 2011 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner **Baltimore City** The Johns Hopkins Hospital 8. Date of Birth (Month, Day,) Oct 31 If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign 5. Social Security Number 6. Sex 7. Age (In vrs. last birthday) **Funeral** Days Hours Year) 1 ₹M 2 □ F 1944 215-40-4255 66 Maryland Director Usual Residence of Decedent with the Maryland 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location show 1 ☐ Yes 2 📉 No Maryland Anne Arundel Director items 23a or 28a-f s ner must be notified Annapolis 10g. Citizen of What Country? 10e. Street and Number 10f. Zip-Code 205 Victor Parkway Apt B 21403 USA by Funeral Pages 1 and 2 should be filed within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status "natural", or iten X Yes 2 No If Yes, Give Year or Dates: 1964-70 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 💢 No Specify: Specify: **Black** 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry the Medical Decedent's Education (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) and Mental Hygiene.

is marked other than 12th 0 <u>Business Owner</u> Restaurant 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be မ Lawrence T. Brown <u> Marion Turner</u> 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) of Health Item 27 Tonya Lewis(Daughter) 136 Janelin Ct. Glen Burnie, Md. 21061 other 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Department of H
Important: If Ite
any injury or ot 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 3-29-11 Metro Crematory Baltimore, Md. 21. Signature of Funeral Service Licensee Windame Redese of Boilisons Mortuary, P.A. Tarry 1. Reese 821 West St. Annapolis,
23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, 821 West St. Annapolis, Md. 21401 Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line. Immediate Cause (Final Cardio mura Due to (or as a cins ruence of): **Physician** disease or condition resulting in death) //Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of): The law requires that the death certificate be executed burial-transi and Due to (or as a consequence of): attending physician Box 68760, Physician/Medical the as IF FEMALE: use 23c. If yes, outcome of pregnancy 23d, Date of delivery 23b. Was decedent pregnant ☐ Live birth 2 ☐ Fetal death 3 Ectopic pregnancy in the past 12 months? Month Day Year be detached for 4 Pregnant at time of death 5 Other (specify) 2 🗌 No P.O. 9 Unknown 9 Unknown þ 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ Division of Vital Records. 2 No 3 Probably 4 Unknown 1 🗌 Yes Completed page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 2 No 1 Yes or Attending Physician: 25. Was case referred to medical funeral director. 26. Place of Death (Check only one) Be 1 Yes 2 No Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 ER/Outpatient 3 DOA 1 Inpatient မှ 28a. Date of Injury (Month, Day Year) 27. Manner of Death 1 Natural 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: s after death. Injury 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident the 3 Suicide Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide within 24 hours a

To the Funeral D

completely filled To the Hospital 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical (check only 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) RES-000 March 25 2011 VI

State Registrar

31. Date filed (Month, Day, Year) MAR 3 0 2011

Registrar's Signature barker

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

600 North Wolfe St, Baltimore, MD, 21287

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene for State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death March Physician/ Virginia D. Boyle 2011 3:59 A Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Baltimore Pickersgill Retirement Community Towson Social Security Number . Age (In vrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth g. Birthplace (State or Foreign **Funeral** (Month, Day, Yea 98 Hours 218-03-6790 1 □ M 2 🛛 **Director** Maryland Usual Residence of Decedent or 28a-f show notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director Baltimore Towson MD 1 ☐ Yes 2 X No 10e. Street and Number 10f. Zip Code ō 10g. Citizen of What Country? must be n Funeral 21204 615 Chestnut Avenue ?7 is marked other than "natural", or items traumatic event, the Medical Examiner mu Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian Armed Forces?

1 Yes 2 XNo Black, White, etc. þ 1 Never Married 2 Married Maryland 21215-0036 White If Yes, Give Year or Dates 1 ☐ Yes 2 X No Specify Completed 3 XWidowed 4 ☐ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) College (1-4 or 5+) Elementary/Seconday (0-12) Homemaker should be filed with h and Mental Hygien 7 is marked other th Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Marion Harding George Dahm 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
19 Cavan Drive Lutherville, MD 21093 permit. Page 1 and 2 sh
Department of Health an
Important: If item 27 is
any injury or other trau Tina Boyle Moran / Daughter Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State March 31 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) St. Peter s Church Cemetery Libertytown, MD 2011 21. Signature of Juneral Service Ligens Barranco & Sons, P.A. Severna Park Funeral Home 495 Ritchie Hwy, Severna Park, MD 21146 23a. Part 1. Enter the disease, or conshock, or heart failure. List only ations that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Immediate Cause (Final Onset and Death Physician ADVANCED disease condition resultion in death) Medical Due to (or as a consequence of Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of): Exami Cause (Disease or iinjury Hospital or Attending Physician: The law requires that the death certificate be executed and that initiated events resulting in death) Last Due to (or as a consequence of): attending physician I for use as the buria Physician/Medical Box 68760 IF FEMALE . If yes, outcome of pregnancy 1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant in the past 12 months?

1 Yes 2 No 23d. Date of delivery 3 Ctopic pregnancy
5 Other (specify) Month Day Year Pregnant at time of death the P.O. signed by the Part II. <mark>Other signific</mark>an<mark>t conditions</mark> contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? à CEREBRUVASCULAR DISEASE Records, 1 Yes 2 No 3 Probably 4 Unknown Completed PHEUMATOID ARTHRITIS 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an this certificate has all director, page 2 performed 2 - No 1 Tes Division of Vital 25. Was case referred to predica 26. Place of Death ck only one Be examiner? Other: 1 🗌 Yes 2 HNo ည 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of injury (Month, Day, Year) After this 27. Manner of Death 28b. Time of 28c. Injury at work?
1 Yes 2 No Certificate: 28d. Describe how injury occurred 1 Natural iniury 5 Pending n 24 hours after we...he Funeral Director: Af ☐ Accident Investigation 3 ☐ Suicide 4 ☐ Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier Lecrtifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check 3 [only one 29b. Signature and title of certifie 0

State Registrar 30. Name a

address of person who completed cause of death (Item 23a) (Type, Print)

3 0 2017

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death . 2<u>011</u> March 27, **Physician** Bailey 11:15 P ^M Elizabeth /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death **Examiner** 4115 Lee Lane White Plains Charles If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year 12/3/1929 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 6 Sex **Funeral** Days Hours 1 □ M 2**X**XF 81 Yrs. 578-36-2440 Washington, DC Director Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Wedeal Event is a to be pulled at once. 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2√1 No Director Maryland | Charles White Plains 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 20695 USA Funeral 4115 Lee Lane 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11 Marital Status Black, White, etc. 1 Never Married XX Married 1 ☐Yes 2 No Baltimore, Maryland 21215-0036 1 □Yes 2 🔀 💥 o Specify. þ Specify: White 3 Widowed 4 Divorced Year or Dates: Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) 8 years College (1-4or 5+) Homemaker In Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Hazel ဂ Benjamin Franklin Oliver Cassell Cash 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) James S. Bailey / Husband 4115 Lee Lane White Plains, Maryland 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State Maryland Veterans Cem. 4/5/2011 Cheltenham, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service 22. Name and Address of Facility George P. Kalas Funeral Home, P.A. 6160 Oxon Hill Rd., Oxon Hill, MD 20745 Approximate Interval Between Onset and Death 23a. Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final **Physician** D disease or condition resulting in death) 9 /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examiner Due to (or as a consequence of) attending physician and for use as the burial-transit resulting in death) Last Due to (or as a consequence of): Hospital or Attending Physician: The law requires that the death certificate be Physician/Medical 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☒No Month Day Year 5 ☐ Other (specify) 1 ☐ Yes 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. \$ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 🕶 Unknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 2 No 1 □Yes 2 No 1 Yes 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital: 1 | Inpatient 2 | ER/Outpatient 3 | DOA 1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 2 ☐ Accident 5 Pending 1 ☐ Yes 2 ☐ No neral Director: A investigation 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide within 24 hours after To the Funeral Direct Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Krishan Mathur, M.D. 0 70 31. Date filed (Month, Day, Year) 32. Registrar's Signature State

DHMH 17 Rev 1/2001

Registrar

MAR 3 0 2011

P.O. Box 68760.

Division of Vital Records.

Please Type or Print in Black Indelible Ink, Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Physician/ Belk Edith :30 dine. arch Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Medica Plata Charles Conter 0 Security Number If Under 1 Year If Under 24 Hrs 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 🗆 M 2 🕱 F Months Days Hours Min **Director** Usual Residence of Decedent 28a-f show "natural", or items 23a or 28a-f sho edical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 ¥ Yes 2 ☐ No exandria Virginia 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 22314 Queen 5. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian, Was Deceuent ____ Armed Forces? 1 ☐ Yes 2 ☐ No Black, White, etc. Completed by 1 Never Married 2 Married 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 X No Specify. 3 Widowed 4 Divorced Black 27 is marked other than "natur traumatic event, the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Be Baltimore, Maryland Page 1 and 2 should be filed 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) and Mental ൧ Brown laude 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 st Department of Health a Important: If item 27 is McKinle onstance 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State cemetery, crematory or other place) 1 Burial 2 Cremation 3 Removal from State è injury 2011 4 ☐ Donation 5 ☐ Other (Specify) Valle 6 Annandale Viralnia 21. Signet re of Funeral Service Licensee 22. Name and Ad ress of Facility 2107 Carl Ct Be W. MOCVISSETT-J 2, MD. 20607 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory Approximate Interval Between Onset and Death shock, or heart failure. List only one cause Immediate Cause (Final Physician/ disease or condition resulting in death)) Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine IW Monz that the death certificate be executed burial-tran that initiated events resulting in death) Last and to (or as a consequence of): attending physician for use as the burial Completed by Physician/Medical 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery Ectopic pregnancy in the past 12 months?

1 Yes 2 No 5 Other (specify) Month Day Year Pregnant at time of death to the Funeral Director: After this certificate has been signed by the scompleted filled in by the funeral director, page 2 should be detached ☐ Unknowr Part II. Other significant conditions contributing to death but not resulting in the Inderlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? Hospital or Attending Physician: The law requires Division of Vital Records, 1 Yes 2 No 3 ☐ Probably 4 ☐ Unknown 4b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 2 🗌 No 1 Ves 25. Was case referred to edical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 \(\text{Nursing Home} \) 5 \(\text{Residence} \) 6 \(\text{Other} \) Other (Specify) 1 🗌 Yes Certificate: To 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of injury (Month, Day, Year) 27. Man r of Death 28b. Time of 28c. Injury at work? 1 ☐ Yes 2 ☐ No 28d. Describe how injury occurred iniury VNatural 5 Pending Accident Investigation thin 24 hours after death the Funeral Director. 2 Accident
3 Suicide
4 Homicide Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner. On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practionery to the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one 29d. Date signed (Month, Day, Year) 29b. Signature and 30. Name and addre of person who completed cause of death (Item 23a) (Type, Print) 7286 SONA OL 31. Date filed (Month, Day, Year, 32. Redistrar's Signature State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month Year 30 4 10:28 PM Jean Starkey Bramble March 2011 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death Many land Medical Center Baltimore University of Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 🗆 M 2 🕱 F Days Hours Director 79 06/08/1931 WASHINGTON, D.C. <u> 222-18-1359</u> Usual Residence of Decedent show or 28a-f shove notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 XYes 2 No QUEEN ANNE'S MD CRUMPTON 10e, Street and Number 10f. Zip Code ò 10g. Citizen of What Country? ms 23a or must be r Funeral 218 SECOND STREET 21628 UNITED STATES Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status Was Deceus.. Armed Forces? ⁴ ☐ Yes 2 **X** No 14. Race - American Indian, the Medical Examiner Black, White, etc. þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 ☐ No Specify: "natural", Specify: Completed 3 X Widowed 4 Divorced WHITE 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) filed within 72 tal Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) HOUSE KEEPER DOMESTIC 11 other traumatic event. Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) should be file h and Mental F 7 is marked of ၉ UNKNOWN MARTHA STARKEY 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 shr Department of Health an Important: If item 27 is any injury or other trau once. 18374 SOUTH MAIN STREET BRIDGEVILLE, DE 19933 JIMMY WALLS / SON 20b. Place of Disposition (Name of cemetery, crematory or other place 20a. Method of Disposition 20c. Location - City or Town, State 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) CRUMPTON CEMETERY 04/03/2011 CRUMPTON, MARYLAND 21. Signature of Funeral Service Licenses 22. Name and Address of Facility FELLOWS RHELFENBEIN & NEWNAM FUNERAL HOME 130 SPEER ROAD CHESTERTOWN, MARYLAND 21620 23a. Part. Enter the disease, or complication show, or heart failure. List only one caus that caused the de in Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ Bactend Endocarditis disease or condition resulting in death) Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or imjury Due to (or as a consequence of) Examir as the burial-transit death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): by the attending physician Physician/Medical Box 68760 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death nse 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregna 5 ☐ Other (specify) Ectopic pregnancy ρ in the past 12 months?
1 ☐ Yes 2 🔀 No Month Dav Year Pregnant at time of death been signed by the should be detached ☐ Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Records, Completed 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🕱 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an cate has page 2 s autopsy perform certificate Yes 2X No Division of Vital To the Funeral Director: After this certific completed filled in by the funeral director, 25. Was case referred to medical or Attending Physician: Be 26. Place of Death (Check only one) examiner? 1 🗌 Yes 2 🗶 No Other: 2 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) Certificate: 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 X Natural 2 Accident 5 Pending hours after death. 1 ☐ Yes 2 ☐ No Investigation 3 Suicide 4 Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) To the Hospital within 24 hours a To the Funeral D Hospital Medical 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 131626 2876 March 30, 2011 24 8 MD 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 22 S. Greene Street, Baltimore 40 2/201 Horitha Icataliam, MO bark 31. Date filed (Month, Day, Year) Registra s Signature State

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene, Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month ^{Day} 2011 Spencer Beebe Clyde April 2:30 Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b City Town, or Location of Death 4c. County of Death St. Mary's Hospital St. Mary's Leonardtown 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 XM 2 □ F Days Hours Min. (Month, Day, Year) 12/02/1931 Pennsylvania Months **Director** 79 165-26-9195 Usual Residence of Decedent ishow 10a. State 10b. County be filed within 72 hours after death with the Maryland 27 is marked other than "natural", or items 23a or 28a-f sho traumatic event, the Medical Examiner must be notified at 10c. City. Town or Location 10d. Inside City Limits Director 1 Yes 2X No Maryland St. Mary's Charlotte Hall 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 29449 Charlotte Hall Rd. 20622 S Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces?

1 Yes 2 No
If Yes, Give
Year or Dates. Black, White, etc. Completed by 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 Yes 2 X No Specify: Specify: White 3 ☐ Widowed 4 🗓 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working al Hygiene. life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Chef Food Service Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) and Mental F ည Orrie Clyde Beebe Susan Spencer permit. Page 1 and 2 should be Department of Health and Men Important: If item 27 is marke any injury or other traumatic 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Maxine B. Hufnagel/Sister 660 Willow Valley Square, Apt. M411, Lancaster, 20c. Location - City or Town, State 17602 20a. Method of Disposition 20b. Place of Disposition (Name of 1 🗆 Burial 2 🖾 Cremation 3 🗆 Removal from State cemetery, crematory or other place) Brinsfield-Echols Crem. 04/03/2011 Charlotte Hall, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service License 22. Name and Address of Facility Brinsfield-Echols F.H., P.A. MOO817 30195 Three Notch Rd., Charlotte Hall, MD 20622 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Onset and Death Immediate Cause (Final ABDOMINAL ADRTIC ANEURYSM Pnysician/ RUPTURED disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Examine Due to (or as a consequence of) resulting in death) Last Due to (or as a consequence of) Physician/Medical P.O. Box 68760 IE FEMALE 23b. Was decedent pregnant 23d. Date of delivery To the Hospital or Attending Physician: The law requires that the death in the past 12 months? Day Yes 2 No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by DIABETES MELLITUS Division of Vital Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 X Unknown 24b. Were autopsy findings available prior to completion of cause of 24a. Was an has 1 Yes 2 No Yes Be 25. Was case referred to medical 26. Place of Death (Check only one) Hospital 1 ☐ Yes 2 🗙 No မှ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify, 27. Manner of Death Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 5 Pending injury 1 ☐ Yes 2 ☐ No ☐ Accident ☐ Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, ☐ Homicide determined 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29c. License number D 61758 29d. Date signed (Month, Day, Year) APRIL I, 2011 29b. Signature ag MD

Registrar DHMH 17 Rev 7/2009

State

RPE

MARYLAND

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

TOHN HARVEY, ST MARY'S HOSPITAL, LEONARDTOWN,

Registrar's Signature

HARVEY

JOHN 31. Date filed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 1- For Amend Item 24a State of Maryland Department of Health and Mental Hygiene Registrar 12269 1. Decedent's Name (First, Middle, Last) 2. Date of Death March Physician/ 2011 Frances Virginia Blake 2320 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Atlantic General Hospital **Berlin** Worcester 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign 8. Date of Birth **Funeral** Months Days Hours Min. June 9, 1926 Country) MD 221-18-1116 84 Director Usual Residence of Decedent Department of Health and Mental Hygiene. Important, or items 23a or 28a-f show Important; if item 27 is marked other than "natural", or items 23a or 28a-f show important; if item 27 is marked other than any injury or other traumatic event, the Medical Examiner must be notified at anone. 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director Worcester Bishopville 1 🙀 Yes 2 🗆 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 9747 Hotel Road 21813 USA 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No If Yes, Give Year or Dates. 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, ^{te, etc.} African– ģ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify. Specify: Completed 3 ₩ Widowed 4 □ Divorced American 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) and Mental Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) 8 Line Worker Poultry Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ဂ္ဂ Arthur Townsend Elizabeth Pitts 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Delores Blake/daughter 9747 Hotel Road, Bishopville, MD 21813 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 🔀 Burial 2 🗆 Cremation 3 🗆 Removal from State Curtis UMC Cemetery 4 ☐ Donation 5 ☐ Other (Specify) 04/02/2011 Bishopville, MD 21. Signature of Euneral Service Licensee ^{22, Name and Address of Facility}
Lewis N. Watson Funeral Home, PA
1618 West Road, Salisbury, MD 21801 Jo. Walson 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Sepsis

Due to or as a consequence of): Physician/ disease or condition resulting in death) Medical Examiner Sequentially list conditions Due to lor as a consequence of cause. Enter Underlying the attending physician and hed for use as the burial-transit Cause (Disease or iiniur) that initiated events resulting in death) Last Due to (or as a consequence of) Completed by Physician/Medical Hospital or Attending Physician: The law requires that the death certificate be IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death
9 Unknown 23b. Was decedent pregnant 23d, Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?
1 Yes 2 No Day Year 1 Yes 2 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Nnknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 No 1 Yes 2 No Division of Vital Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital 1 ☐ Yes 2 ☐ No Other: ၉ 1 Inpatient 2 ER/Outpatient 3 IDOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) Certificate: 27. Manner of Death 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred 5 Pending Natural 2 Accident
3 Suicide
4 Homicide 1 Yes 2 No Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Continuing Nurse Practice 2: The basis of my kill wholes, death occurred at the time, date and place, and due to the cause(s) and manner is stated. 29d. Date signed (Month, Day, Year)

March 28, 2011 29c. License number **D 543**0**7** 29b. Signa ranzamond MD 317. 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
Dr. Van Egmord, Atlantic General, 9733 Healthway Drive, Berlin, MD 21811

Registrar

DHMH 17 Rev 7/2009

State

31. Date filed (Month, Day, Year)

2011

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day OLY Year Month 04 11:00 PM Physician/ Bridges Myrtle Medical 4c. County of Death 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** Allegany Cumberland WHMS-RMC Birthplace (State or Foreign Country) MD If Under 1 Year If Under 24 Hrs. 8. Date of Birth 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** 1 □ M 2 □**y** Davs Hours Min. Mut 64 1928 213-24-5087 Director 82 Usual Residence of Decedent show 10c. City, Town or Location
Mt.Savage 10d. Inside City Limits 10b. County 10a State Director other traumatic event, the Medical Examiner must be notified MD Allegany 28a-f 1 Xes 2 No 10g. Citizen of What Country? 10f. Zip Code 5 10e. Street and Number 21545 USA 23a 15106 Mt. Savage Road items 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No If Yes, Give Year or Dates. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, "natural", or þ 1 Never Married 2 Married permit. Page 1 and 2 should be filed within 72 hours after toppartment of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or any injury or other traumatic event, the Medical Examin 1 Yes 2 No Baltimore, Maryland 21215-0036 Specify: white Specify 3 ☐ Widowed 4 ☐ Divorced Completed 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) own home homemaker Be 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Bessie (McKenzie) McKenzie Oscar McKenzie 19b. Mailing Address (Street and Number or Bural Route Number, City or Town, State, Zip Code) 21545 14900 Mt. Savage Road Mt. Savage MD 21545 19a. Informant's Name/Relationship (Type, Print) daughter **Brenda Bloss** 20c. Location - City or Town, State 20a. Method of Disposition 20b. Place of Disposition (Name of Date Burial 2 ☐ Cremation 3 ☐ Removal from State Restlawn Memorial Gardens 4/8/201 LaVale MD → Qonation 5 ☐ Other (Specify) Signatule of Funeral Service Licensee 22. Name and defense fiffe differal Home, PA 108 Virginia Avenue: Cumberland, MD 21502 23a. Part J. Bhter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final Approximate Interval Between Onset and Death mule Physician/ disease or condition resulting in death) Medical Examiner wanny Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury Examine enrs To the Hospital or Attending Physician: The law requires that the death certificate be executed within 2t hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the kinneral director, page 2 should be detached for use as the burial-transit that initiated events Due to (or resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant Live Birth 2 Li retail 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months?

1 Yes 2 No Month Day 1 Yes 2 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause giver Part 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 No 1 Yes 2 No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 1 🗌 Yes 2 📉 No 1 ☐ Inpatient 2 ★ER/Outpatient 3 ☐ DOA မ 4 Nursing Home 5 Residence 6 Other (Specify) 28c. Injury at work? 1 ☐ Yes 2 ☐ No Manner of Death 28a. Date of injury (Month, Day, Year) 28h Time of 28d. Describe how injury occurred Certificate: 1 Natural 5 Pending Accident Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 - Homicide determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one 29b. Signature ar 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar

DHMH 17 Rev 7/2009

State

31. Date filed (Month, Day, Year)

13500 WILLOW

RD. CUMBERLAND

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Marc 06 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Medical Arundel Anne Arundel Center Annapolis Anne If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign 5. Social Security Number 6. Sex 8. Date of Birth Age (In yrs. last birthday) **Funeral** 1 □ M 2🏋 F Months Hours Min Feb 26 Maryland Director 219-28-2805 75 Usual Residence of Decedent ral", or items 23a or 28a-f show Examiner must be notified at 10b. County 10a. State 10c. City, Town or Location 10d. Inside City Limits 72 hours after death with the Maryland Director 1 ☐ Yes 2 🔀 No Anne Arundel Maryland Annapolis 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 1103 Smithville St. Unit 109 21401 USA 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. , or Completed by 1 Never Married 2 Married 1 Yes : 2 💢 No Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify: **Black** "natural", 3 ♥ Widowed 4 □ Divorced Year or Dates event, the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) th and Mental Hygiene.
27 is marked other than traumatic event, the Me Elementary/Seconday (0-12) Page 1 and 2 should be filed within ment of Health and Mental Hygiene. College (1-4 or 5+) 9th \cap Cosmetologist <u>Ashley Nicols Salon</u> Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 William H. Turner <u>Elizabeth Kyler</u> 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health ar Important: If item 27 is any injury or other trac Phyllis Collins(Daughter) 1102 Tace Dr. Apt 3C 21221 Essex, Md. 20a. Method of Disposition 20b. Bees to spestice (Name of 20c. Location - City or Town, State Date or other place) 1
☐ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify) Memorial Park 4-4-11 Annapolis, Md. Miname aRacasseof RecilitySons Mortuary, P.A. 21. Signature of Funeral Service Licenses 821 West St. Annapolis, Md. 21401 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition Medical resulting in death) Due to (or as a consequence Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Examine Due to (or as a consequence of) use as the burial-transit Hospital or Attending Physician: The law requires that the death certificate be executed and that initiated events resulting in death) Last Due to (or as a consequence of) physician Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?
1 Yes 2 No ρ Day Year Pregnant at time of death been signed by the sahould be detached Unknown 9 Unknown significant conditions contributing to death that not resulting in the phderlying cause given in Part I. Part II. Other 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 has performed abete 1 Yes 2 No Yes 2, No within 24 hours after death.

To the Funeral Director: After this certific completed filled in by the funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 2 No Other: 2 1 Tes 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 28a. Date of injury 27. Manner of Deat 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred (Month, Day, Year) 1 Natural 2 Accident 5 Pending 1 🗌 Yes 2 🗌 No Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 3 🗌 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. To the 29b. Signature and title of certifie 00565 State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death . Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month 04:25AM Sheila L. Medical Corbin 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death the Wicomic shur at Birthplace (State or Foreign Country) If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth **Funeral** 1 🗆 M 2 🕱 F Months Min. Director 54 -1956 <u> 220-68-8038</u> Usual Residence of Decedent Department of Health and Mental Hygiene, Important, or items 23a or 28a-f show Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at any injury or other traumatic event, the Medical Examiner must be notified at anones. 10a. State 10c. City, Town or Location 10d. Inside City Limits Director MD Somerset Princess Anne 1 Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 30505 Valentine Drive 21853 USA Page 1 and 2 should be filed within 72 hours after death ment of Health and Mental Hygiene. 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Yes 2 XNo
If Yes, Give
Year or Dates. 1 Never Married 2 X Married Completed by Maryland 21215-0036 1 ☐ Yes 2 X No Specify: 3 Widowed 4 Divorced Speciallack 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Holly Center C.N.A Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ၉ <u>Willie Baker</u> Iris Doane 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1853 19a. Informant's Name/Relationship (Type, Print) 30505 Valentine Drive, Corbin, Sr./Husband Princess Anne. Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 4-2-2011 Princess Anne, MD Wesley Cem Service L 22. Name and Address of Facility Bennie Smith Funeral Home 917 W. Isabella St. Salisbury, MD 21801 23a. Part 1 Enter the disease, or complications that caused shock, or heart failure. List only one cause on each line. for the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ CHRONIC KIDNRY DISRASE disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner Sequentially list conditions, day, reading to introduct cause. Enter Underlying Cause (Disease or iinjury Due to for sels consecuence on Hospital or Attending Physiclan: The law requires that the death certificate be executed attending physician and for use as the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of): Completed by Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) ____ in the past 12 months? Month Day Year Pregnant at time of death been signed by the s should be detached g Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Onknown 24 hours after death.

Funeral Director: After this certificate has been 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 autopsy performed' Yes 2 1 Tes funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: ၉ 1 Tes 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred Natural 5 Pending work 1 Yes 2 No Accident Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier To the I within 2. To the F only one 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 31. Date filed (Marth Ry), Registrar's Signature State Registrar

Baltimore, Maryland 21215-0036 Division of Vital Records, P.O. Box 68760

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Funeral		5. Social Security N	umber	6. Sex 1 M 2	7. Age (In yrs.		Mo	Under 1 Year onths Days	If Unde	r 24 Hrs. Min.	8. Date of Bir	Voor		9. Birt	hplace (State or For	reign	
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uld be 1 Menta narkec natic e	2	James C									alvucci						
permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.			C. Dash	hip (Type, Print) / Husbane		12	208 1	ddress (Street a Farley									
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To the Hospital or Attending Physician: The law requires that the death certificate be within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physicic completed filled in by the funeral director, page 2 should be detached for use as the but the but the funeral director.	Physician/Medica	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 1 Pregnant at time of death 5 Other (specify) 23d. Date of Month 2 Month 2										lvery Day Year					
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To t To t		29b. Signature and	title of certifier		7	7		29c. License	number	10	P	29d. Da	ate signed	(Month	, Day, Year)		
H15		30. Name and addre	ess of person	who completed caus		m 23a) (Typ	pe, Print)	Ste. 106	6	den R	(um) =	mh	. a	1001			
Stat Registra	te ar	31. Date filed (Mont)	h, Day, Year) MAR 3 () 2011 32. B	gistrar's Sign		par	Ked	, -		7						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Day 2011 DAVID CORNELIUS DONOVAN, JR. APRIL 3:55A Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City. Town, or Location of Death 4c. County of Death 8 BYFORD COURT CHESTERTOWN **KENT** Social Security Numbe If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 7. Age (In vrs. last birthday) 8 Date of Birth 9. Birthplace (State or Foreign Funeral 1 XM 2 - F 12/03/1928 Director NEW YORK 82 097-20-8315 ms 23a or 28a-f show must be notified at 10a. State 10b County 10c. City, Town or Location 10d. Inside City Limits Director 1 X Yes 2 No MD KENT CHESTERTOWN 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? items 23a Funeral 8 BYFORD COURT 21620 UNITED STATES 12. Was Decedent Ever in U.S. Armed Forces?

1 X Yes 2 □ No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, . or ! Black, White, etc. 1 Never Married 2 Married \$ Baltimore, Maryland 21215-0036 1 Yes 2 XNo Specify: "natural", Completed 3X Widowed 4 ☐ Divorced WHITE Year or Dates the Medical Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) other than Elementary/Seconday (0-12) College (1-4 or 5+) should be filed within and Mental Hygiene. **PATHOLOGIST** MEDICAL Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) DAVID CORNELIUS DONOVAN, SR. JANE AGNES 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 sh Department of Health a Important: If item 27 is any injury or other trai once. 1166 SILVER BEECH ROAD HERNDON, VIRGINIA 20170 DAVID C. DONOVAN / SON 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 N Burial 2 Cremation 3 Removal from State cemetery, crematory or other place) 4 Donation 5 Other (Specify) FRANCIS XAVIER 04/12/2011 MARCELLUS, NEW YORK 21. Signature of Funeral Service Licenses 22. Name and Address of Facility
FELLOWS, HELFENBEIN & NEWNAM FUNERAL
130 SPEER ROAD CHESTERTOWN, MARYLAND Kich of & 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Dea Physician/ CONGESTIVE HEART FAILURE disease or condition month Medical resulting in death) Due to (or as a consequence of): Examiner AURTIC STENOSIS Sequentially list conditions Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Due to (or as a consequence of) sician and burial-transit Due to (or as a consequence of) resulting in death) Last Physician/Medical 68760 for use as 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 3 Ectopic pregnancy

5 Other (specify) IF FEMALE 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months? Dav Year 1 Yes 2 9 Unknown 2 No g Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by CORONARY ARTERY DISEASE Records, 1 Yes 2 No 3 Probably 4 Unknown FALURE TOTHRIVE 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an performed? Yes 2 No BIPOLAR DISORDER 2 No 1 Yes Division of Vital Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? 1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: ျှ 1 Inpatient 2 ER/Outpatient 3 DOA Manner of Death 28a. Date of injury 28b. Time of Certificate: 28c. Injury at work? 28d. Describe how injury occurred Hospital or Attending 1 Natural
2 Accident
3 Suicide
4 Homicide (Month, Day, Year) 5 Pending 1 Yes 2 No Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by determined To the Hospital within 24 hours a To the Funeral I Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 🗆 Certifying Nurse Practioner. To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier D004158

Registrar

DHMH 17 Rev 7/2009

State

Helen

31. Date filed (Month, Day, Year)

CHESTERTOWN

back

MU

SPEER RD

32. Registra s Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

22

Noble

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.
State of Maryland / Department of Health and Mental Hygiene 1 For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Day / Melvin J. Dunford Month 2 2:0 Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death COASTAL HOSPICE AT THE LAKE SALISBURY WICOMICO 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Min 1 X M 2 - F Days Hours (Month, Day, Year) 02/12/1937 74 West Virginia Director Yrs <u>213-34-7577</u> Usual Residence of Decedent 28a-f shov 10b. County 10c. City, Town or Location within 72 hours after death with the Maryland injury or other traumatic event, the Medical Examiner must be notified at 10d. Inside City Limits Director 1 🗌 Yes 2 🔀 No Maryland Wicomico Parsonsburg ь 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? "natural", or items 23a Completed by Funeral 7967 Jones Hastings Road 21849 USA 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian. Armed Forces?
1 ☐ Yes 2 🔀 No Black, White, etc. 1 Never Married 2 Married 21215-0036 1 Yes 2 X No Specify: If Yes Give Specify: white 3 Widowed 4 Divorced Year or Dates 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Hatchery Worker Perdue Farms Be Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) .. Page 1 and 2 should be filed tment of Health and Mental H tant: If item 27 is marked ot မ Harley Dunford Lucille Reece 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 8166 Del Haven Rd., Baltimore, MD 21222 Stan Baranowski/step-brother Baltimore, Department of Heal 20b. Place of Disposition (Name of 20a. Method of Disposition Date 20c. Location - City or Town, State 1 X Burial 2 Cremation 3 Removal from State Springhill Memory Gardens 4 ☐ Donation 5 ☐ Other (Specify) 4/2/2011 Hebron, MD 21. Signature of Funeral Service Ligensee any ir Phonioway Funeral Home Professional Association Kell 501 Snow Hill Rd., Salisbury, MD 21804 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner ASCVO Sequentially list conditions, if any leading to find solutions. Enter Underlying Examiner as a consequence of attending physician and for use as the burial-transit Cause (Disease or linjury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Hospital or Attending Physician; The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 3 Ectopic pregnancy

5 Other (specify) IF FEMALE 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?
1 ☐ Yes 2 ☐ No signed by the atte Month Day Year 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by CofD 1 🗌 Yes 2 🗍 No 3 Probably 4 ☐ Unknown certificate has been sirector, page 2 should 24b. Were autopsy findings available 24a. Was an autopsy performed? prior to completion of cause of death? 1 ☐ Yes 2 ☐ No Yes 2 🗶 No Be (25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital 2 No Other: ပ္ 1 🗌 Yes Hispire of 1 Inpatient 2 ER/Outpatient 3 IDOA 4 \square Nursing Home 5 \square Residence 6 \square Other (Specify) After this 28a. Date of injury (Month, Day, Year) 27. Manper of Death 28b. Time of 28c. Injury at work? 1 ☐ Yes 2 ☐ No Colol Certificate: 28d. Describe how injury occurred injury Natural Natural 5 Pending Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) in by 4 Homicide determined 24 hours a Medical 🕊 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier within 24 hor To the Fune completed fi Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) and title of certifier 29b. Signatu 29c. License number 29d. Date signed (Month, Day, Year) 63199 3/26/11 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) VOHRA 910 SALISBURY HA 21804 YOGESH EASTERN SHOPE 31. Date filed (Month, Day, Year) 1 2011 State Registrar

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Please Type or Print in Black Indelible Ink, Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygien For State Registrar Certificate of Death Reg. No. ent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month 201 Medical Facility Name (if not institution, give street and number, Examiner 4c. County of Death town 6. Sex If Under 1 Year If Under 24 Hrs 8. Date of Birth **Funeral** 9. Birthplace (State or Foreign 1 🗆 M 2 🕱 F Days Months Hours 08/26/1929 NEW YORK Director 132-22-3081 81 Usual Residence of Decedent ral", or items 23a or 28a-f show Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 XYes 2 No CHESTERTOWN MD KENT 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? Funeral 205 WALDO DRIVE 21620 UNITED STATES 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Was Decedent Ever in U.S. 11. Marital Status Race - American Indian. Armed Forces Black. White, etc. Completed by 1 Never Married 2 Married 2 No Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify: WHITE If Yes, Give than "natural", 3 Widowed 4 Divorced Year or Dates. 1951-52 permit. Page 1 and 2 should be filed within 72 hour. Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natur any injury or other traumatic event, the Medical I 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) REGISTERED NURSE HEALTH CARE Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ၉ WILLIAM LYON LENA WEISENBERGER 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 205 WALDO DRIVE CHESTERTOWN, <u>JAMES F. DAVIS, JR./HUSBAND</u> MARYLAND 21620 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 Burial 2X Cremation 3 Removal from State cemetery, crematory or other place) 4 ☐ Donation 5 ☐ Other (Specify) CHESAPEAKE CREMATION 03/30/2011 STEVENSVILLE, MARYLAND 21. Signature of Funeral Service Licenses 22. Name and Address of Facilit FELLOWS, HELFENBEIN & NEWNAM FUNERAL HOME, 130 SPEER ROAD CHESTERTOWN, MARYLAND 21620 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, lock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition Medical resulting in death) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or and I-transit Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events Due to (or as resulting in death) Last physician a Physician/Medical attending pl IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?

1 Yes No
9 Unknown Month Pregnant at time of death Day Year 9 Unknown signed by the Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has page performed eukovenin 2 🗌 No 1 🗌 Yes Yes 20 No Be 25. Was case referred to medice funeral director. 26. Place of Death (Check only one) examiner? Other: 1 Tes 2 No ည this 1 M Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28b. Time of Certificate: 28a. Date of injury 28c. Injury at 28d. Describe how injury occurred (Month, Day, Year) Natural Natural 5 Pending after death.

Director: Aft
d in by the fur 1 Yes 2 No Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined npleted filled Medical 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. To the P within 2 29b. Signature and title of 2011 6 30. Name and address o eted cause of death (Item 23a) (Type Chererioun N.D. 100 51. BROWN State Registrar

DHMH 17 Rev 7/2009

Box 68760

P.O.

Records,

Division of Vital

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene for State Registrar Certificate of Death Reg. Ng. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 2011 April 2245 Goddard Evelyn Gatton Medical 4b. City, Town, or Location of Death 4a. Facility Name (if not institution, give street and number) 4c. County of Death **Examiner** St. Mary's Callaway Hospice House of St. Mary's 8. Date of Birth
Dec 19, If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign . Age (In yrs. last birthday) Funeral 1 🗆 M 2 🗶 F Hours Maryland 89 219-12-3943 Director Usual Residence of Decedent 10d. Inside City Limits permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at any injury or other traumatic event, the Medical Examiner must be 10a. State 10b. County 10c. City, Town or Location Director 1 ☐ Yes 2 X No Maryland St. Mary's Great Mills 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral U.S.A. 20698 Goddard Road 20634 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Was Decedent Ever in U.S. 11. Marital Status Armed Forces?
1 ☐ Yes 2 ☐ XNo Black White etc. by 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 Yes 2 XNo Specify: Specify: White If Yes, Give 3 ▼ Widowed 4 □ Divorced Completed Year or Dates 16b. Kind of Business Industry 15 Decedent's Education 16a Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) College (1-4 or 5+) Elementary/Seconday (0-12) Education Teacher 12 Be 17, Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 Lola C. Taylor Pirly I. Gatton 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19283 Flat Iron RD., Valley Lee, MD 20692 Robert Goddard Jr./Son 20a. Method of Disposition
1 ★Burial 2 □ Cremation 3 □ Removal from State 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 4 ☐ Donation 5 ☐ Other (Specify) 4/12/2011 | Great Mills. MD Face 22. Name and Address of Facility Brinsfield Funeral Home, P.A. 21. Signature of Funeral Service Licensee 22955 Hollywood Rd., Leonardtown, MD 20650 Danielle Ward M01403 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line. Immediate Cause (Final FAILURE Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner 6 MONTHS Sequentially list conditions Examine it any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury YEKS attending physician and for use as the burial-transit Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events Due to (or as a consequence of) resulting in death) Last CAWCER (0) Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant Live Birth 2 Fetal death 3 Ectopic pregna 5 Other (specify) Ectopic pregnancy in the past 12 months?

1 Yes 2 No
9 Unknown Month Day Pregnant at time of death 4 ☐ Pregnant 9 ☐ Unknown been signed by the should be detached Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by ERTIC ULOSIS 2X No 3 ☐ Probably 4 ☐ Unknown 1 Yes Completed 24b. Were autopsy findings available prior to completion of cause of death? BLEED 24a. Was an autopsy performed? Yes 2 No After this certificate has I 2 No 1 Yes Hospice 25. Was case referred to medical examiner?

1 Yes 2 No 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 X Other (Specify, House ျ 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 28b. Time of 27. Manner of Death 28c. Injury at 28d. Describe how injury occurred Certificate: 1 X Natural 5 Pending work' 1 Yes 2 No 2 Accident
3 Suicide
4 Homicide Accident Suicide Investigation within 24 hours after deat To the Funeral Director: 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier

State Registrar

DHMH 17 Rev 7/2009

(Check

only one)

29b. Signature and title of certifier

31. Date filed (Month, Day, Year)

FRANK KALGER, MD

APR 08

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

#207-40900 Merchants Cane/Leonard town, MD ZOGSC

29d, Date signed (Month, Day, Year)

4/6/1

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29c. License number

D50350

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene? For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Vear King L. Gullette 1500 PM Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Regional ninsula comico If Under 8. Date of Birth (Month, Day, 9. Birthplace (State or Foreign Country) Maryland Security Number 7. Age (In yrs. last birthday) If Under 24 Hrs. Funeral Days 1 X M 2 D F Months Min. Hours 82 Yrs **Director** 215-26-4123 Usual Residence of Decedent 28a-f show with the Maryland 10a. State 10b. County 10c. City, Town or Location Examiner must be notified at 10d. Inside City Limits Director 1 🗌 Yes 2 🔀 No DE Laurel Sussex 10e. Street and Number 10f. Zip Code ò 10g. Citizen of What Country? Funeral 23a 7262 Airport Road 19956 USA items within 72 hours after death 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status 14. Race - American Indian, rmed Forces?

2 Yes 2 No Black, White, etc. permit. Page 1 and 2 should be filed within 72 hours after or Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or i þ 1 Never Married 2 Married 1966 Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 Yes 2 No Specify: white 3 Widowed 4 Divorced Specify: Completed event, the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) manufacturing welder Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ဂ Lemuel Gullette Virginia B. Ryan 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Alma Gullette (Wife) 7262 Airport Road Laurel, DE 19956 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date or cemetery, crematory or other place) 1 X Burial 2 Cremation 3 Removal from State Springhill Memory Gard Mar. 31, 2011 injury Hebron, Maryland 4 Donation 5 Other (Specify) Signature of Funeral Service Licensee 22. Name and Address of Facility Short Funeral Home 19940 East Grove Street Delmar, DE 23a. Part 1. Enter the disease, or complication shock, or heast failure. List only one caus sease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Immediate Cause (Final disease or condition resulting in death) Onset and Death Physician Medical Due to (or as a consequence of): Examine Sequentially list conditions Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a considence of To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery Ectopic pregnancy in the past 12 months? Month Day Year Other (specify) Pregnant at time of death 9 Unknown Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Winknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 2 1 No 1 Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 2 No ၉ 1 Inpatient 2 I ER/Outpatient 3 I DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 28c. Injury at Certificate: 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 1 Natural work? 5 Pending injury 2 No Accident Suicide Investigation Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifie 29d. Date signed (Month, Day, Year) 110 of death (Item 23a) (Type, Print) (Month, Day, Year) State MAR Registrar

DHMH 17 Rev 7/2009

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month **Physician** APRIL 2, 6:40 P ANNE H. HYNSON 2011 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner HERON POINT CHESTERTOWN **KENT** Birthplace (State or Foreign Country) If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Hours Months 1 ☐ M 2 【 F Davs **Director** 01/16/1928 NEW YORK 086-52-3116 83 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a State 10b. County 28a-f show traumatic event, the Medical Examiner must be notified at 1 Xes 2 No Director KENT CHESTERTOWN MD 10g Citizen of What Country? 10e. Street and Number 10f. Zip Code ö UNITED STATES **501 EAST CAMPUS AVENUE** 21620 Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. Pages 1 and 2 should be filed within 72 hours after Never Married 2 Married Baltimore, Maryland 21215-0036 ō 1 ☐ Yes 2 🗶 No Specify: þ 3 Widowed 4 Divorced WHITE Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: If item 27 is marked other than 'any Injury or other traumatic event, the Magnetic apprecia College (1-4or 5+) Elementary/Secondary (0-12) 0 NONE 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be LELIA HODSON 2 JAMES NELSON HYNSON 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 8 WHITE TAIL DRIVE ROCKPORT, MAINE 04856 SARA HOPKINS / SISTER 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Date 1 N Burial 2 ☐ Cremation 3 ☐ Removal from State 4 Donation 5 Dother (Specify) ALL HALLOWS CEMETERY: 04/07/2011 SNOWHILL, MARYLAND 21. Signature of Funeral Service Licenses 22. Name and Address of Facility
FELLOWS, HELFENBEIN & NEWNAM FUNERAL HOME, P.A. Kirky afec. 130 SPEER ROAD CHESTETOWN, MARYLAND 21620 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) days **Physician** PANCREATITY. /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Unstiffing Cause (Disease or injury that initiated events resulting in death) Last Examine Due to (or as a consequence of) or Attending Physician; The law requires that the death certificate be executed Due to (or as a consequence of): Box 68760. Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No
9 Unknown Month Year Day 5 Other (specify) Ö 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, þ DEMINUTIA 2 No 3 Probably 4 Unknown Completed MENTAL RETARDATION 24b. Were autopsy findings available prior to completion of cause of death?
1 □Yes 2▼No 24a Was an autopsy performed? Yes 2 No THRIVE 70 FAILURE Division of Vital 1 ☐ Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 1 Yes 2 No Hospital: Other: Certification: To 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) this 27. Manner of Leath 1 Natural 2 Accident 28a. Date of Injury (Month, Day, Year) 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending 1 ☐ Yes 2 ☐ No investigation within 24 hours after death To the Funeral Director: completely filled in by the 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide Hospital 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State Registrar 31. Date filed (Month, Day, Year)

DHMH 17 Rev 1/200

ms

Name and address of person who completed cause of death (Item 23a) (Type, Print) Chestertown, ND 21620

32. Registrar's Signature

0041587

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month 305 PM Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** ANCHORAGE NURSING + REHABILITATION NTER SALISBURY WICOMICO 5. Social Security Number 225–10–1320 7. Age (In yrs. last birthday) If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 M 2 X F Months Hours 02/07/1917 Director 94 Georgia Usual Residence of Decedent 23a or 28a-f show 10a, State 10b. County 10c. City, Town or Location must be notified at 10d. Inside City Limits Director 1 X Yes 2 No Maryland Wicomico Salisbury 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 1110 Healthway Drive 21804 USA items within 72 hours after death 11. Marital Status 12. Was Decedent Ever in U.S 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14 Bace - American Indian Examiner Armed Forces?
1 ☐ Yes 2 🕶 No Yes, specify Cuban, Mexican, Puerto Rican, etc. Black, White, etc. "natural", or ģ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 Yes 2 X No Specify: If Yes. Give Specify: Completed 3 X Widowed 4 Divorced white Year or Dates the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) Department of Health and Mental Hygiene. Important: If item 27 is marked other than any injury or other traumatic event, the Me Wicomico County Board Elementary/Seconday (0-12) College (1-4 or 5+) of Education Receptionist/secretary Be should be filed 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Robert Edward Herrell Sally Blount Mason 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 9028 Davis Rd., Pittsville, MD 21850 Stephen A. Heatwole/son Page 1 and 2 20a Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State permit. Page 1 and Department of h 1 X Burial 2 Cremation 3 Removal from State Wicomico Memorial

Park 4 Donation 5 Other (Specify) 3/31/2011 Salisbury, MD Storotur of Funeral Service Licensee Holloway Funeral Home Professional Association 501 Snow Hill Rd., Salisbury, MD 21804 4 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest Approximate shock, or heart failure. List only one cause on each line Interval Between Onset and Death Immediate Cause (Final Physician/ thrive 0 disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner omen Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Examine Due to (or as a consequence of) ASC The law requires that the death certificate be executed and burial-tran that initiated events Due to (or as a consequence of): resulting in death) Last attending physician Physician/Medical Box 68760 the as IF FEMALE: Se 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?

1 Yes 2 No 3 Ectopic pregnancy for Month Pregnant at time of death 5 Other (specify) the 9 \ Unknown 9 Unknown Division of Vital Records, P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 2 No 3 Probably 4 Unknown Completed been 24b. Were autopsy findings available prior to completion of cause of death? 24a, Was an has autopsy perform this certificate 1 ☐ Yes 2 ☐ No or Attending Physician: the funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: Certificate: To 2 NO 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred within 24 hours after death.

To the Funeral Director: After Natural 5 Pending 1 🗌 Yes 2 No Investigation 6 Could not be Accident Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide determined Hospital Medical 🗠 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 67c 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DHMH 17 Rev 7/2009

State Registrar 31. Date filed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			4 101	State of Maryland / D				Mental Hyo	giene			
			State Registrar 1. Decedent's Name (First, Middle, Last)		Cer	tificate of D	eath		Reg. No		12281	
	Physicia Medic		Geny Pereira Inman					2. Date of Dea March 2	29, Da 201 1	Year	3. Time of Death 3:00 AM	1
4.6	Examin	er	4a. Facility Name (if not institution, give street 2305 Nancarles Driv			4b. City, Town, or Gambrill		h	4c. County Anne	of Death	del	
Ē	Funeral Director		5. Social Security Number 6. Sex 1 1 N	7. Age (In yrs. last birth)	day) 'rs.	If Under 1 Year Months Days	If Under 24 Hrs Hours Min.		7, 1910	g. Birthp Count Braz	olace (State or Foreign	n
	how how	r	Usual Residence of Decedent 10a, State 10b, County	10c. City, Town	or Loc	ation				1	0d. Inside City Limits	
	farylar 8a-f sl tified	Director	Maryland Anne Arund							- [1 🗆 Yes 2 🛭 N	
	a or 2 be no		10e. Street and Number	1 334,000		10f. Zip Code			10g. Citizen of	What Coun	itry?	_
	th with ms 23 must	Funeral	2305 Nancarles Driv			21054			U.S.A.			
(C)	er dea or iter niner	by Fu	11. Marital Status1 □ Never Married2 □ Married	Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 🙀 No	13. V	Vas Decedent of His Yes, specify Cubar	spanic Origin? (S n, Mexican, Puerl	pecify Yes or No- to Rican, etc.)		ce - Americ ck, White, e		
Baltimore, Maryland 21215-0036	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Heath and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	ted t	3 X Widowed 4 Divorced	If Yes, Give Year or Dates.		Yes 2 No			Specify	Whit	e	
75	72 ho in "na Medic	Completed	15. Decedent's Educa (Specify only highest grade of	ompleted) (Give k	ent's Usual Occupa ind of work done do NOT use retired)	ation uring most of wo	rking	16b. Kind of B	usiness Inc	dustry	
212	within rgiene. ner than t, the N		Elementary/Seconday (0-12)	College (1-4 or 5+)		her			Educat	ion		
and	e filed ntal Hy ed oth event	To Be	17. Father's Name (First, Middle, Last)					me (First, Middle, i Thebald		e)		
aryl	should be file and Mental I 7 is marked c raumatic eve		Antonio Joao Perei 19a. Informant's Name/Relationship (Type, I		Mailin	g Address (Street a				State Zin C	Pode)	_
Ĕ	id 2 sh salth a n 27 is er trau		Mary Ann Ventresca			Nancarle			-			
ore	ge 1 and it of Heal if item or other		20a. Method of Disposition 1XXBurial 2 ☐ Cremation 3 ☐ Ren	20b. Place of providing state	Dispos , crem	sition (Name of	a)	Date	20c. Location	•		
Iţi	nit. Page artment o ortant: If injury or		4 Donation 5 Other (Specify) 21. Signature of Funeral Service Licensee	Garden	S 22	Memorial Name and Address	04/0	2/2011	Davidso	nvill	e, Maryla	nc
Ba	permit. Departn Importa any injt	d d	alle Surve			000 Anna						
•	Pnysician/ Medical Examiner	er .	23a. Part 1. Enter the disease, or complicate shock, or heart failure. List only one call immediate Cause (Final disease or condition resulting in death)	Due to (or as a consequence of	J	r the mode of dying	g, such as cardiad	c or respiratory arr	est, aj/u	re	Approximate Interval Between Onset and Death	5
	outed nd ransit	camine	If any, leading to in modiate cause. Enter Underlying Cause (Disease or iinjury that initiated events	Directs (or as a nonsequence or								
09	icate be executed physician and s the burial-transit	dical Examiner	resulting in death) Last	Due to (or as a consequence of):							
Box 6876	ath certif attending for use a	/Me	in the past 12 months?	If yes, outcome of pregnancy 1 ☐ Live Birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 9 ☐ Unknown		Ectopic pregnancy Other (specify)	y			ate of deliver	ery Day Year	
, P.O.	res that the dessigned by the signed by the signed by the signed by the signed is the	by Ph	Part II. Other significant conditions contrib	outing to death but not resulting in	the ur	nderlying cause give	en in Part I.				e cause of death?	
ords	require been si should	letec						1 🗆 \			oably 4 ☐ Unknow	
Reco	Physician: The law In this certificate has be and lirector, page 2 s	Somp						autop perfor	rmed?		mpletion of cause of	
ta	ician: certifica ector, l	Be	25. Was case referred to medical examiner?	nital:		1	ice of Death (Che					
of Vi	Phys or this caral dir	e: 10	TLI Yes 2 No	1 Inpatient 2 ER/Outp 28a. Date of injury 28b. Tir		t 3 DOA Other	4 ☐ Nursing I	dome 5 X Resid)	_
on (anding sath. or: Afte	ficat	1 Natural 5 Pending 2 Accident Investigation	(Month, Day, Year) inj	ury	work?	? Yes 2□No		, -,			
Division of Vital Records,	al or Atte s after de l Directo d in by th	Certificate:	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of Injury - At home, farm building, etc. (Specify)	n, stre	et, factory, office		28f. Location (S City or Tow		er or Rural	Route Number,	
_	To the Hospital or Attending Ph within 24 hours after death. To the Funeral Director: After th completed filled in by the funeral	Medical	(Check 2 Medical Examiner:	n: To the best of my knowledge, do On the basis of examination and/or actioner: To the best of my knowle	investi	gation, in my opinior	n, death occurred	at the time, date as	nd place, and du	e to the cau	use(s) and manner stat	ted.
	To th withir To th сощр	2	29b. Signature and title of certifier	A No sect of thy knowled	-90, U	29c. License			29d. Date signe	d (Month, L	Day, Year)	
			Law Stran	71		D36	203		3-29	-20	2/1	
1	#12		30. Name and address of person who comp Dr tan Shontz	2401 Brandes		ill Blud	Stez	SO Gan	abrills 1	70	21054.	
	Stat Registra		31. Date filed (Mon) MAR 37 0 2011	32. Degistrar's Signature	160	all						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene, for State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 2011 March Virginia Η. Johnson 24 12:10 PM Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death 649 Lakeland Road South Severna Park Anne Arundel Social Security Number 8. Date of Birth (Month, Day, Ye June 22 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign **Funeral** 1 🗆 M 2 🛛 F Hours 220-14-3211 Director 1921 <u>June</u> Pennsylvania Usual Residence of Decedent or 28a-f show notified at 10a. State 10b. County filed within 72 hours after death with the Maryland 10c. City, Town or Location Director 10d. Inside City Limits MD Anne Arundel Severna Park 1 Yes 2X No 10e. Street and Number 0 10f. Zip Code 10g, Citizen of What Country? than "natural", or items 23a or Funeral 649 Lakeland Road South 21146 USA 11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. þ 1 Never Married 2 Married Yes 2 No Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 X No Specify: White Completed Specify. 3 X Widowed 4 ☐ Divorced 15. Decedent's Education 16a, Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) and Mental Hygiene. 육 Homemaker **Home** Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) permit. Page 1 and 2 should be fi Department of Health and Mental Important: If item 27 is marked any injury or other traumatic ev onee. 2 Edgar Horn Mary Kelley 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Barbara Palmer / Daughter Annapolis, MD 21405 215 Nottingham Hill 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) cemetery, crematory or other place)
Dulaney Valley Memorial
Gardens March 28, Timonium, MD 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Barranco & Sons, P.A. Severna Park Funeral Home 495 Ritchie Hwy, Severna Park, MD 21146 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final edron Ydr Attil Onset and Death Physician/ disease or condition Medical resulting in death) Due to (or **ENGSTNON** Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of e Hospital or Attending Physician: The law requires that the death certificate be executed 124 hours after death.

Funeral Director: After this certificate has been signed by the attending physician and the burial-transi Cause (Disease or linjury that initiated events resulting in death) Last Due to (or as a consequence of): **Director.** After this certificate has been signed by the attending physician in by the funeral director, page 2 should be detached for use as the burial Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy Live Birth 2 Fetal dea
Pregnant at time of death in the past 12 months? 5 Other (specify) Month Day Year 9 Unknown 9 Unkr Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 2 No 3 Probably 4 Unknown 1 Yes 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy No perform 1 L Yes Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 1 🗌 Yes Certificate: To 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28d. Describe how injury occurred 27. Manner of De 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work?
1 Yes 2 No injury Natural 5 Pending Investigation Accident 6 Could not be Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) Homicide determined completed filled Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nupse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check within 2 only one 29b. Signat License number 29d. Date signed (Month, Day, Year) mpleted cause of death (Item 23a) (Type, Print) 0. Name ar

State Registrar 31. Date filed (Month

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Laura Keturah Johnson 3Day 20// 13:57 Medical 3 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death TENINSULA NICOMICO 5. Social Security Number **Funeral** 8. Date of Birth 9. Birthplace (State or Foreign 1 □ M 2 🏝 F Davs 224-68-8016 Months Hours Min 05/31/1956 54 **Director** Maryland Usual Residence of Decedent 28a-f shov 10a. State 10b. County 10c. City, Town or Location by Funeral Director 10d. Inside City Limits er than "natural", or items 23a or 28a-fs the Medical Examiner must be notified Maryland Wicomico Fruitland 1 X Yes 2 No 10f. Zip Code 10g. Citizen of What Country? 102 Olde Field Court 21826 USA 11. Marital Status Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian Armed Forces?

1 Yes 2 No
If Yes, Give Black, White, etc. 1 Never Married 2 Married 1 Yes 2 No Specify: 3 Divorced 4 Divorced white Completed Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) al Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) homemaker domestic Be 17. Father's Name (First, Middle, Last) and Mental F 18. Mother's Name (First, Middle, Maiden Surname) i. Page 1 and 2 should be fill timent of Health and Mental tant: If item 27 is marked or မ William Bozman Dolly Catlin 19a. Informant's Name/Relationship (Type, Print) 9b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 102 Olde Field Court, Fruitland, MD 21826 Leon Johnson Jr/spouse 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) permit. Page 1 a Department of I Important: If ite any injury or ot 20c. Location - City or Town, State 1 Burial 2X Cremation 3 Removal from State 4 Donation 5 Other (Specify) 3/31/2011 Salisbury Crematory Salisbury, MD 21. Signature Holloway Fuheral Home Professional Association 501 Snow Hill Rd., Salisbury, MD 21826 22a. Part 1/ Enter the disease, or complications that cal shook, or heart failure. List only one cause on each ed the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition Physician/ Molnution Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Examine Due to (or as a consequence of): that the death certificate be executed that initiated events resulting in death) Last physician all s the burial-t Due to (or as a consequence of): Physician/Medical attending pl IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?

1 Yes 2 No
9 Unknown Pregnant at time of death 5 Other (specify) Month Day Year been signed by the should be detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobaccouse contribute to the cause of death? þ Completed 1 ☑ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 s has autonsv performed Yes 2 1 Yes funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) 1 Yes Other: ည 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) this 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred To the Hospital or Attending 1 Matural 5 Pending within 24 hours after death.

To the Funeral Director: A Accident 1 Yes 2 No Investigation filled in by the Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier completed Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check 29b. Signature and title of 29c. License number 129 10056197

Burp

Maryland 21215-0036

Baltimore,

Box 68760

P.O.

Records,

Division of Vital

Registrar
DHMH 17 Rev 7/2009

State

31. Date filed (Mo.

Cignoll St. Skrisby mb 2180

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Physician/ . 2011 Walter James Keeler 27 March 1730 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Anne Arundel Medical Center <u>Annapolis</u> Arundel . Social Security Number If Under 1 Year If Under 8. Date of Birth 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday, **Funeral** Days Hours Min. 11/13/1932 1 😾 M 2 🗆 F Washington DC 577-42-9952 78 Director Usual Residence of Decedent 28a-f show 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits traumatic event, the Medical Examiner must be notified at Director MD Anne Arundel 1 Yes 2XXNo Crownsville 10e. Street and Number 10f. Zip Code ŏ 10g. Citizen of What Country? 23a Funeral 1137 Valentine Creek Drive 21032 USA permit. Page 1 and 2 should be filed within 72 hours after death 1 Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14 Race - American Indian Armed Forces?

1 X Yes 2 No If Yes, Give Year or Dates. Black, White, etc. 1 Never Married 2 X Married Š Maryland 21215-0036 1 ☐ Yes 2 🔀 No Specify: Specify: White Completed 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business Industry NSA Elementary/Seconday (0-12) Colleger(1+4 or 5+) Engineer Specialist Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Walter Jacob Keeler Violet Hanselman 19a, Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Marlene M. Keeler Wife 1137 Valentine Creek Drive Crownsville, MD 21032 injury or other Baltimore, . Method of Disposition
1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State Maryland Veterans 03/31/2011 Crownsville,MD 21032 4 Donation 5 Other (Specify) 21. Signature of Funcial Service Lio 22. Name and Address of Facility 851 Annapolis Road Hardesty Funeral Home P.A.Gambrills, MD 21054 any at 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line Immediate Cause (Final Ph sician/ Medical resulting in death) Due to (or a a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Examine Due to (or as a consequence of): ysician and e burial-transit that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): attending physician Physician/Medical Division of Vital Records, P.O. Box 68760 the use as IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy for in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Pregnant at time of death 5 Other (specify) Year been signed by the should be detached 1 ☐ Yes 2 ☐ Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an cate has by page 2 s autopsy Hospital or Attending Physician: The certificate 1 ☐ Yes 2 ☐ No within 24 hours after death.

To the Funeral Director: After this certific completed filled in by the funeral director, 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No Hospital: 1 🗌 Yes မှု 1 Inpatient 2 ER/Outpatient 3 I DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 5 Pending iniury 1 ☐ Yes 2 ☐ No ☐ Accident Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) the 29b. Signature 29d. Date signed (Month, Day, Year) 0060225 March 28, 2011 of person who completed cause of death (Item 23a) (Type, Print) 30. Name nd addres Anne Arundel Medical Center Annapolis, MD 21401

Registrar DHMH 17 Rev 7/2009

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distrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3 Time of Death **Physician** 5:25 PM 20 l /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner FutureCare Chesapeake Anne Arundel Arnold If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 8. Date of Birth (Month, Day, 7. Age (In vrs. last birthday) **Funeral** 90 Months Days Hours 1 □ M 2 🕅 F 053-12-1301 Director 06,1921 New York Jan. Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits show item 27 Is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Wedden Evan har the national at Director MD Anne Arundel Arnold 1 □Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21012 **USA** 305 College Parkway Funeral 12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ☑ No 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status within 72 hours after 1 Never Married 2 Married Baltimore, Maryland 21215-0036 White þ If Yes, Give Year or Dates: 1 ☐ Yes 2 XNo Specify 3 XWidowed 4 ☐ Divorced Completed 16a Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Medical Records Clerk Hospital 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be 2 should be fii and Mental H Louis DeRosso Rose Cresci ဥ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1 and 2 s' if Health a Robert M. Katz/ Son 900 Rock Dove Court Arnold, MD 21012 permit. Pages 1 and Department of Healt Important; If item 2; any Injury or other t 20b. Place of Disposition (Name of cemelery, crematory or other place)
St. Mary of the Lake Cemetery 2011 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 X Removal from State Lakewood, NJ 4□Donation 5 XOther (Specify)Entombment 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Barranco & Sons, P.A. Severna Park Funeral Home 495 Ritchie Hwy, Severna Park, MD 21146 Approximate Interval Between Onset and Death 23a. Part 1. Enter the lisease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final **Physician** daus disease or condition resulting in death) /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Exami be executed burial-trar Due to (or as a consequence of) Box 68760. attending physician Physician/Medical the as IF FEMALE use 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 Live birth 2 Fetal death 4 Pregnant at time of death 3 Ectopic pregnancy in the past 12 mon for Month 5 Other (specify) P.0. the 9 Unknown is been signed by the should be detached Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, à 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? has page 2 s autopsy performe this certificate 2 No 1 □Yes 2 N Hospital or Attending Physician: Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Invursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes Certification: To 1 Inpatient 2 ER/Outpatient 3 DOA funeral 27. Mann - of Death 1 atural 28a. Date of Injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred After 5 Pending investigation death. 1 ☐Yes 2 🗆 No 2 Accident the Funeral Director: mpletely filled in by the 6 □ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide hours Tertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical 24 and manner stated ပ္ 3-28-2011 rars Hwy Millersville MD 21108 Name and address of person who completed cause of death (Item 23a) (Type, Print

Registrar

State

MAR 3 0 2011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Herbert B. Kilgoe Medical 4b. City, Town, or Location of Death 4a. Facility Name (if not institution, give street and number) 4c. County of Death **Examiner** Daliobur) i comic Regimal 6.00x medical Center ninsula If Under 1 Year If Under 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Days Min. (Month, Day, DE Country) 1 □ M 2 💢 F Director 954 222-40-8313 Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified. 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 No Seaford Sussex DE 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number Funeral 19973 USA 30406 N. Oak Grove Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, 11. Marital Status Armed Forces Black, White, etc. ģ 1 X Never Married 2 Married 1 Yes Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Spe**B**lack 3 Widowed 4 Divorced Completed Year or Dates. 16a. Decedent's Usual Occupation 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Advance Auto Parts 12 <u>Store Manager</u> Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Nettie Kilgoe Herbert Cannon 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1152, Hurlock, MD21643 Brenda Hooper/Friend PO Box 20c. Location - City or Town, State 20a. Method of Disposition 20b. Place of Disposition (Name of Date 1 Nurial 2 Cremation 3 Removal from State cemetery, crematory or other place) 4-2-2011 Seaford, DE 4 Donation 5 Other (Specify) Middleford Cem 22. Name and Address of Facility 917 W. Isabella St. f Juneral Service Li Bennie Smith 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Onset and Death Immediate Cause (Final Physician/ SCHEMIC ARDIOMY OPATH disease or condition resulting in death) Medical Due to (or as a consequence of) **Examiner** ORONARY Sequentially list conditions, Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of) Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and I for use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months?
1 ☐ Yes 2 ☐ No Year Month Day Pregnant at time of death Unknown been signed by the should be detach Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 5 1 Yes 2 № No 3 □ Probably 4 □ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performed? Yes 2 No after death.

Director: After this certificate | 1 Yes 2 No 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 2**X** No မ Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify completed filled in by the funeral 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: 1 Natural 5 Pending 1 Tes 2 No Accident
Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 24 hours 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check Ceptifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) within 2 To the I 29b. Signature and title ၉ 046536

State Registrar 31. Date filed (Month, Day, Year)

100 E. CARROLL ST

SALISBURY MD 21801

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

11-02713 Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. David Lombardo State of Maryland / Department of Health and Mental Hygiene 1- For State Certificate of Death Registrar Reg. No. Physician/ 1. Decedent's Name (First, Middle,Last) 2. Date of Death 3. Time of Death Madical Examiner - David Lombardo 0232 hrs David Anthony Lombardo April 9, 2011 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Anne Arundel Medical Center Annapolis Anne Arundel 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24Hrs. 8. Date of Birth (MM/DD/YYYY) 9. Birthplace (State or **Funeral** Director 096-58-6975 1 X M 2 F 34 04/11/1976 Country) Yrs NY Usual Residence of Decedent 10a, State 10c. City, Town or Location 10d. Inside City Limits 28a-f shov 1 Yes 2 X No smat be notified at once. Anne Arundel Crofton death with the Maryland 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1741 Tarrytown Ave. ā 21114 USA items 23a Funeral 11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specity Yes or No-14. Race - American Indian, Black, Armed Forces? If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 X Never Married 2 Married 2X No Yes è more, MD 21215-0036
Pages 1 and 2 should be filed within 72 hours after of the aft and Mental Hygiene.
and If the 27 is marked other than "natural", of your other transatic event, the Medical Emminar protects are other transatic event, the Medical Emminary. White 4 Divorced Give Yeer 1 Yes 2 X No specify: Specify. Ś 15. Decedent's Education (Specity only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done 16b. Kind of Business/Industry Completed during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Mental Health Services Counselor 17. Father's Name (First, Middle, Last) 18.Mother's Name (First, Middle, Majden Surname) å David D. Lombardo Maryann V. Widnick 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) David D. Lombardo / Father 1741 Tarrytown Ave., Crofton, MD 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, Date 20c. Location - City or Town, State crematory or other place) 1 X Burial 2 Cremation 3 Removal from State Department of Lakemont Memorial Grd. 4/15/2011 Davidsonville, MD 4 Donation 5 Other Specify: 6 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Beall Funeral Home 6512 NW Crain Hwy., Bowie, MD Physician are fise disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Approximate Interval failure. List only one cause on each line Retween Onset and /Medical Death Cocaine Intoxication Immediate Cause (Final disease ≟xaminer or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, Examine if any, leading to immediate cause. Enter Underlying Cause Due to (or as a consequence of): (Disease or injury that initiated Due to (or as a consequence of): events resulting in death) Last the attending physician and ed for use as the burial - transit ician/Medical \mathbf{x} AMENDED 1,23a,27,28a-f per me g915 5-9-11 vt X UNPENDED IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant in the 2 Fetal death 1 Live birth 3 Ectopic pregnancy Day past 12 months? Pregnant at time of death Other (Spenify) signed by the atte 1 Yes 2 No 9 Unknown Physi 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ੬ Completed 24a. Was an autopsy performed? ✓ Yes 2 No

Division of Vital Records, P.O. Box 68760, this certificate has been a director, page 2 should l this certificate has After within 24 hours after death filled in by the

Be

Medical

State Registrar 29b. Signature and title of certifier

Patricia Aronica-Pollak MD.

30. Name and address of person who completed cause of death (Item 23a)

OCME

Year 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 ✔ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 1 Yes 2 No 25. Was case referred to medical 26.Place of Death (Check only one) examiner? Hospital: 1 Inpatient 2 🗹 ER/Outpatient 3 🗌 DOA Other Nursing Home 5 Residence 6 Other 1 Yes 27. Manner of Death 28b. Time of Injury 28a. Date of Injury (Month, Day, Year) 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending 1 Yes 2 No fd 4-9-11 fd 1:42am unknown 2 Accident Investigation 28e. Place of Injury - At home, farm, street, factory, office building, etc. 28f. Location (Street and Number or Rural Route Number, City or Town, State) 1741 Terrytown Ave Crofton, Md. 3 Suicide 6 X Could not be (Specify) Homicide at home 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 W Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. License number

O.C.M.E.

111 Penn Street, Baltimore, MD 21201

29d, Date signed (Month, Day, Year)

April 9, 2011

DHMH 17 Rev 1/2001 **OCME 2006**

ORIGINAL

Assistant Medical Examiner

32. Registrar's Signature

Baltimore, Maryland 21215-0036 Division of Vital Records, P.O. Box 68760

	A	MEND#AMEND#26 per PHY 1 - State Registrar 3/28/2011 AAC	State of Marylan	d / Depa <i>Cert</i>	rtment of ificate of	Health and Death	Mental Hy	giene Reg. No.	011 1228			
		Decedent's Name (First, Middle, Las					2. Date of De	eath	3. Time of Death			
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min		4a. Facility Name (if not institution, give	street and number)		4b. City, Town,	, or Location of Dea	th		unty of Death			
		1529 CEDARHURST		-1.5.46.4	SHADY If Under 1 Yea		0 D D (D)		E ARUNDEL			
eral ctor		5. Social Security Number 6. So 018–22–6911 Usual Residence of Decedent	PX 7. Age (In yrs. la	Yrs.	Months Day			1930	9. Birthplace (State or Fore. Country) MASSACHUSETTS			
at	5	10a. State 10b. County	10c. City	, Town or Loca	ation				10d. Inside City Limi			
"natural", or items 23a or 28a-f show edical Examiner must be notified at	Director	MARYLAND ANNE ARI	INDEL SHA	ADY SID	E				1 ☐ Yes 2 X			
oe uc		10e. Street and Number			10f. Zip Code	9		10g. Citizen	of What Country?			
ısnu	Funeral	1529 CEDARHURST I	ROAD		2076			USA	·			
ner r		11. Marital Status	12. Was Decedent Ever in U.S Armed Forces?	. 13. W	as Decedent of Yes, specify Cu	f Hispanic Origin? (S ıban, Mexican, Puer	Specify Yes or No to Rican, etc.)		Race - American Indian, Black, White, etc.			
хаш	d by	1 ☐ Never Married 2 🔀 Married 3 ☐ Widowed 4 ☐ Divorced	1 Yes 2 XNo	1	☐ Yes 2 🛣 N	No Specify:		Spe	cify: WHITE			
cal	Completed	15. Decedent's E		16a. Decede	ent's Usual Occ	upation		16b. Kind	of Business Industry			
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r, me		12		ADMINI	STRATIV	VE SUPPOR	T CLERK	ADMI	NISTRATION			
even	To Be	17. Father's Name (First, Middle, Last)					ame (First, Middle		name)			
other traumatic event, the medical	-	EDWARD NORTHROP					A BOYNTO					
traun		19a. Informant's Name/Relationship (T)							ın, State, Zip Code)			
au l		JOHN L. LEBER/HUS 20a. Method of Disposition	20b. P	lace of Dispos	ition (Name of	URST ROAD	Date Date		MD_ZU/64 ion - City or Town, State			
any injury or or on once.		1 ☐ Burial 2 X Cremation 3 ☐	Removal from State	Metery creme	CREMA	LION 03						
infu a		4 ☐ Donation 5 ☐ Other (Specif 21. Signature of Tuneral Service Licens					ACTING T	DIEVE	NSVILLE, MD			
onc		16/1			LFENBE	INE&TNEWN	AN CREMA	NAPOT	S BY FELLOWS, IS, MD 21401			
≗ I	al Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events resulting in death) Last b. Due to (or as a consequence of): c. Due to (or as a consequence of):										
gred by the attending physicion of detached for use as the but by Dhycicion/Medica	by Physician/Medica	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23c. If yes, outcome of pregnancy 23d. Date of outcome of pregnancy 3 Ectopic pregnancy 4 Pregnant at time of death 5 Other (specify) Month 10 M										
	Completed b						24a. Was		4b. Were autopsy findings availat prior to completion of cause death? 1 Yes 2 No			
, diecioi,	Be	25. Was case referred to medical examiner?	Hospital:	110		Place of Death (Ch	eck only one)					
₹ l	은	1 ☐ Yes 2 🗹 No 27, Manner of Death	1 Inpatient 2	28b. Time of	3 □ DOA 28c. Inj		Home 5 Res					
5	ate	1 ☑ Natural 5 ☐ Pending	(Month, Day, Year)	injury	W	pury at ork? ☐ Yes 2 ☐ No	28d. Describe	now injury oc	curred			
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o iii by tire	i = 1		sician: To the best of my knowle				and due to the c	ause(s) and m	nanner as stated.			
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pieted illed iii by the	Medica	only one) 3 L Certifying Nurs			29c. Lice	nse number		29d. Date s	gned (Month, Day, Year)			
completed illed in by the	Medical	only one) 3 L Certifying Nurse 29b. Signature and title of certifier	7 11									
מיייי שופים ווויפט וויי בא נויפ			_ ,MD		HI		4		23/2011			
W Completed illed in by the			completed cause of death (Item	23a) (Type, Pr		MD-1470						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death March 26,2011 Physician/ 4:25 PM M Philip James Murphy Medical 4b. City, Town, or Location of Death 4a. Facility Name (if not institution, give street and number) 4c. County of Death **Examiner** Anne Arundel 1275 Cape Saint Claire Raod Annapolis If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign . Age (In vrs. last birthday Funeral Min. Months Hours 0670271951 Washington DC 59 213-56-0949 Director Usual Residence of Decedent or 28a-f show 10d. Inside City Limits 10b. County th and Mental Hygiene. 27 is marked other than "natural", or items 23a or 28a-f sho traumatic event, the Medical Examiner must be notified at 10a, State 10c. City. Town or Location be filed within 72 hours after death with the Maryland Director 1 Tyes 2 X No MD Anne Arundel Annapolis 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number Funeral 21409 USA 1275 Cape Saint Claire Road 13. Was Decedent of Hispanic Origin? (Specity Yes or No-12. Was Decedent Ever in U.S. 14 Race - American Indian Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. þ 1 Never Married 2 Married Yes 2 X No Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 🔽 No Specify: White 3 Widowed 4 Divorced Completed 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Painter Contractor Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) မ Philip Jerome Murphy Gertrude Hawkins and 2 should be fine the and Me tem 27 is mark 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1275 Cape Saint Claire Rd. Annapolis, MD 21409 Wife Pamela Murphy other 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a, Method of Disposition permit. Page 1
Department of I
Important: If it
any injury or of 5 ☐ Burial 2 Cremation 3 ☐ Removal from State 3/31/2011 Glen Burnie, MD Atlantic Crematory 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility . Signature of Funeral Service Licer Hardesty Funeral Home P.A.Annapolis Maryland 21401 Saly 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest. Interval Retween Onset and Deat Immediate Cause (Final Physician/ disease or condition Medical resulting in death) Examiner Sequentially list conditions Examiner Sue to (or as a consequence by If any, leading to immedicause. Enter Underlying or Attending Physician: The law requires that the death certificate be executed Cause (Disease or iinjury that initiated events Due to (or as a consequence of) resulting in death) Last the burialphysician Physician/Medical Division of Vital Records, P.O. Box 68760 use as IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ þ in the past 12 months? Month Day Year Pregnant at time of death Yes 2 No s been signed by the s ☐ Unknown g Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an cate has t autopsy performe 1 ☐ Yes 2 ☐ No certificate 1 ☐ Yes 2 No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Hospital: 1 🗌 Yes 2 X No မ 1 Inpatient 2 I ER/Outpatient 3 I DOA 4 Nursing Home 5 Residence 6 Other (Specify) After this funeral dir Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: injury work?
1 Yes 2 No 1 Natural 5 Pending within 24 hours after death.

To the Funeral Director: Af completed filled in by the fu Accident Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Hospital Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a, Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion in my opinion as the time, date and place, and due to the cause(s) and manner as stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29c. License number 201 leteld cause of death (Item 23a) (Type, Print) ess of person D2106 31. Date filed (Month, Day, Registrar's Signature State

DHMH 17 Rev 7/2009

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Physician/ MARCH 29. 8:45AM BEATRICE ANN MERCER Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** KENT CHESTERTOWN CHESTER RIVER HOSPITAL CENTER If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday **Funeral** Hours 1 🗆 M 2 🗶 (Month, Day, Year) 04/17/1934 NEW JERSEY **Director** 76 203-26-5580 Usual Residence of Decedent items 23a or 28a-f show ner must be notified at 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location within 72 hours after death with the Maryland Director 1 X Yes 2 No MD ROCK HALL KENT 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number Funeral UNITED STATES 21661 5628 CIRCLE PARK DRIVE 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. 11. Marital Status "natural", or ite Armed Forces?

1 Yes 2 No Black, White, etc. ò 1 Never Married 2 Married Maryland 21215-0036 1 Yes 2 X No If Yes, Give Specify: Completed 3 XWidowed 4 Divorced WHITE Year or Dates Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) permit. Page 1 and 2 should be filed within 72 Department of Health and Mental Hygiene. Important: If item 27 is marked other than 'any injury or other traumatic event, the Me Elementary/Seconday (0-12) College (1-4 or 5+) RETAIL SALES CLERK 10 Be 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) 2 **ELIZABETH PRESTON** OTTO FEDERICK GESSNER 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 5628 CIRCLE DRIVE ROCK HALL, MARYLAND 21661 JOHN MERCER / SON Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Date 1 Burial 2 Cremation 3 Removal from State BALTIMORE, MARYLAND 4 X Donation 5 ☐ Other (Specify) 03/30/2011 ANATOMY BOARD 22. Name and Address of Facility
FELLOWS, HELFENBEIN & NEWNAM FUNERAL
130 SPEER ROAD CHESTERTOWN, MARYLAND Signature of Funeral Service Licensee HOME, 21620 art 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final EMPHYSEMA Pnysician/ SEVERE 710 years disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner Sequentially list conditions. Examine if any, leading to immediate cause. Litter Underlying Cause (Disease or linjury Due to (or as a consequence of): attending physician and for use as the burial-transit Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
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1 Yes 2 No
9 Unknown Month Year Day 5 Other (specify) Pregnant at time of death g Unknown signed by the a Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 2 No 3 Probably 4 Unknown 1 Yes Division of Vital Records, been si Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 s autopsy perform 1 ☐ Yes 2 No certificate Yes 2 25. Was case referred to medical 26. Place of Death (Check only one) B B examiner? Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Tes ပ 1 Inpatient 2 ER/Outpatient 3 DOA this funeral 28a. Date of injury (Month, Day, Year) 28b. Time of 27. Manner of Death 28c. Injury at 28d. Describe how injury occurred Certificate: I Director; After to in by the funeral work? 1 Natural 5 Pending 2 🗌 No hours after death. 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by determined within 24 hours a

To the Funeral C

completed filled Medical critifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 3 29b. Signature 0041587 2011 . Name and address of person who completed cause of death (Item 23a) (Type, Print) Chestertown MD 21620 31. Date filed (Month, Day 32, Regis State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ 2011 7:35^P м Ellen Mary Mattingly April Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner St. Mary's St. Mary's Hospital Leonardtown If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign 5. Social Security Number 8. Date of Birth **Funeral** Age (In yrs. last birthday) Hours (Month, Day, Year) May 13, 1924 1 □ M 2 🏝 F Country) Maryland Director 86 219-16-1174 Usual Residence of Decedent Page 1 and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene. Start: If item 27 is marked other than "natural", or items 23a or 28a-f showury or other traumatic event, the Medical Examiner must be notified at 10b. County 10d, Inside City Limits 10a. State 10c. City, Town or Location Director 1X Yes 2 No St. Mary's Leonardtown <u>Maryland</u> 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code Funeral 20650 USA 25585 Point Lookout Road Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ☐ Yes 2 🔀 No If Yes, Give Completed by 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🔀 No Specify: Specify: White 3 🔀 Widowed 4 🗆 Divorced Year or Dates 16a. Decedent's Usual Occupation 16b. Kind of Business Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) 12 Telephone Operator Telephone Company Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) ဂ Adele Burch Steven Montgomery 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Box 728 Patuxent River, Maryland permit. Page 1 and 2 Department of Health Important: If item 27 any injury or other tr 20670 LeRoy Burch Mattingly / Son 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 X Burial 2 Cremation 3 Removal from State April 6, 4 Donation 5 Other (Specify) Leonardtown, Maryland Charles Memorial Gardens 2011 Si man r of Funeral Service Liver 22. Name and Address of Facility Mattingley-Gardiner Funeral Home, P.A. 20650 P.O. Box 270 Leonardtown, Maryland ardene 23a, Part 1. Enter the disease, or comblications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final owel Small Ph_sician/ disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, Examine if any, loading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Hospital or Attending Physician; The law requires that the death certificate be executed and the burial-trar Due to (or as a consequence of): resulting in death) Last attending physician Elevation Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death
4 Pregnant at time of death
9 Unknown 23b. Was decedent pregnant 23d. Date of delivery Ectopic pregnancy in the past 12 month 5 Other (specify) Month Day Year signed by the a 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has autopsy page performed 1 ☐ Yes 2 ☐ No 1 🗌 Yes 2 🔽 Be 25. Was case referred to medical 26. Place of Death (Check only one) funeral director Hospital Other: 4 \(\text{Nursing Home} \) 5 \(\text{Residence} \) 6 \(\text{Other (Specify)} \) 2 No 은 1 Yes 1 Inpatient 2 ER/Outpatient 3 DOA After this 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred Natural injury 5 Pending 1 ☐ Yes 2 ☐ No within 24 hours after death.

To the Funeral Director: After the formula of the f Accident Investigation 6 Could not be 3 ☐ Suicide 4 ☐ Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifier (Check 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier 29d. Date signed (A Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) -2650 Pate uresh 20610

Registrar
DHMH 17 Rev 7/2009

State

Registrar's Signat

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death ^{Day} 2<u>011</u> Month April Physician/ McCallister 3:28 A.MHarrolland John Medical 4c. County of Death 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner Prince Georges Southern Maryland Hospital Center Clinton Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 8. Date of Birth (Month, Day, Year) June 30, 1948 9. Birthplace (State or Foreign **Funeral** Months Country) Maryland 62 Director 217-50-6749 Usual Residence of Decedent show 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location notified at Director 28a-f 1 Yes 2 X No Charlotte Hall Maryland| St. Mary's 10f. Zip Code 10g, Citizen of What Country? 10e. Street and Number ms 23a or must be n Funeral USA 29449 Charlotte Hall Rd. 20622 tal Hygiene. ed other than "natural", or items event, the Medical Examiner mu Page 1 and 2 should be filed within 72 hours after death 1 ment of Health and Mental Hygiene.
ant. If item 27 is marked other than "natural", or items ury or other traumatic event, the Medical Examiner mu 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No 14. Race - American Indian, Armed Forces?

1 Yes 2 No
If Yes, Give
Year or Dates. Yes, specify Cuban, Mexican, Puerto Rican, etc. ģ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 White 1 ☐ Yes 2 X No Specify. Specify Completed 3 Widowed 4 X Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business Industry Elementary/Seconday (0-12) College (1-4 or 5+) Driver Health Services Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) ၉ Dorothy Elizabeth Hoffman Harrolland McCallister 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1321 Gatwick Rd., Glen Burnie, MD 21061 Diane Baker/Sister 20a. Method of Disposition 20b. Place of Disposition (Name of Date Department of I Important: If its any injury or of once. cemetery, crematory or other place 1 🔀 Burial 2 🗆 Cremation 3 🗆 Removal from State 4 Donation 5 Other (Specify) 04/05/2011 Owings Mills, MD Garrison Forest Cem. Signature of Funeral Service Licensee 22. Name and Address of Facility Brinsfield-Echols F.H., P.A. 30195 Three Notch Rd., Charlotte Hall, MD 20622 M00817 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Pnysician/ disease or condition Medical resulting in death) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events resulting in death) Last Due to (or as a consequence or, Exami To the Hospital or Attending Physician: The law requires that the death certificate be executed physician and s the burial-trans Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 attending p IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant Ectopic pregnancy in the past 12 months? Month Day 5 Other (specify) ate has been signed by the page 2 should be detached 9 Unknown Part IL Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an autopsy performed? Yes 2 No 1 ☐ Yes 2 ☐ No filled in by the funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) Certificate: To Be examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) Inpatient 2 ER/Outpatient 3 DOA 24 hours after death. Funeral Director: After this 27. Manner of Death 28c. Injury at work? 1 ☐ Yes 2 ☐ No 28a. Date of injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred 1 Natural 5 Pending Investigation
6 Could not be Accident Suicide Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 \square Homicide determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier within 24 hor

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completed fi 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated
3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) D 52900 Mysician 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

State Registrar MUSA MOMOHMD

APR 0 5 2011

31. Date filed (Month, Day, Year)

12150 Annapolis R

205

Glenn Dale MD20769

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygienes For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Apr 4 Physician/ 2011 McKennev 9:10 AM Henry Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Golden Living Center Cumberland Allegany . Social Security Number If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign Country) MD 7. Age (In vrs. last birthday) 8. Date of Birth **Funeral** Month, Day Days Min 1 JM 2 JF Months Hours 212-38-7127 Director 76 Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show amy injury or other traumatic event, the Medical Examiner must be notified at once. 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director MD Allegany Cumberland 1 XYes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21502 512 Winifred Road USA 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Armed Forces? Black, White, etc. 1 Never Married 2 Married þ Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify: If Yes, Give Year or Dates Specify: Completed 3 Widowed 4 Divorced white 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Disabled n/a Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ္ Ruth E. (Knippenberg) McKenney John H. McKenney Sr. 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code 10 N Liberty Street Apt 407 Cumberland ME Inez Neff sister Cumberland MD 21502 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place, Greenmount Cemetery 1 Burial 2 Cremation 3 Removal from State 4/7/2011 4 Donation 5 Other (Specify) MD Cumberland 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Park Home, PA 108 Virginia Avenue: Cumberland, MD 21502 23a. Part 1 Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ Corona disease or condition Medical resulting in death) **Examiner** Sequentially list conditions, if any leading to immediate cause. Enter Underlying Physician/Medical Examine b Hospital or Attending Physician: The law requires that the death certificate be executed 24 hours after death.
b Hours after death.
certificate has been signed by the attending physician and Cause (Disease or linjury that initiated events signed by the attending physician and dbe detached for use as the burial-tran Due to (or as a consequence of) resulting in death) Last Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregna5 ☐ Other (specify) Ectopic pregnancy in the past 12 months?

1 Yes 2 No Month Day Year Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown Completed Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed Yes 2 2 No 1 🗌 Yes completed filled in by the funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: ျှ 1 Yes 2 X No 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury 28c. Injury at Certificate: 28b. Time of 28d. Describe how injury occurred 1 Natural (Month, Day, Year) 5 Pending 1 🗌 Yes 2 🗌 No Accident Investigation Suicide Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

State Registrar

only one) 29b. Signature and title of certif

31. Date filed (Month, Day,

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registra

29c. License number

00033280

KENT AVENUE CLUMBERLAN

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) April 4, Day Physician 3:15 A M Kenneth Parker Clayton /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner Charles La Plata 8825 Darley Drive 9. Birthplace (State or Foreign Country) **Turkey** If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Months Days Hours 1 M 2 □ F 4, Jan. 1960 **Director** 167-46-6143 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State Show item 27 Is marked other than "natural", or items 23a or 28a-f shor other traumatic event, the "solical Experience in ust be notified at 1 X Yes 2 □ No Alexandria Directo VA 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number Pages 1 and 2 should be filed within 72 hours after death with ment of Health and Mental Hygiene.
ant: If item 27 Is marked other than "natural", or items 23a or ury or other traumatic event, the Medical Experient in until to a unit here. U.S.A. 22302 624 Kings Cloister Circle Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Race - American Indian. 12. Was Decedent Ever in U.S. 11. Marital Status Armed Forces?
1 ☐ Yes 2 Ā No
If Yes, Give
Year or Dates: 1 Never Married 2 Married 1 ☐Yes 2 No Specify: White <u>چ</u> 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) Morgage Morgage Banker 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Mayda Poyrazoglu မ Roy Parker 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 624 Kings Cloister Circle, Alexandria, VA 22302 Sandy Cariffe-Parker Date 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 █ Burial 2 ☐ Cremation 3 ☐ Removal from State permit. Pages
Department o
Important: If
any Injury or
once. 04/08/2011 Alexandria, VA Ivy Hill Cemetery 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Cunningham Funeral Home 21. Signature of Funeral Dervice Licensee 811 Cameron St. Alexandria, VA 22314 ne 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician CON resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, it cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consequence of) Examiner physician and the burial-transit Due to (or as a consequence of): Physician/Medical attending p IF FEMALE 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 1 Live birth 2 Fetal death 4 Pregnant at time of death 3 Ectopic pregnancy Year Month Day 5 ☐ Other (specify) been signed by the should be detached ☐Yes 2☐No 9 I Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ģ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🛩 known Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an cate has I page 2 s autopsy performed? 1 ☐ Yes 2 ☐ No funeral director. 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Desidence 6 Other (Specify) 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Medical Certification: To After this 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Injury 5 Pending investigation 1/1 Natural 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 Suicide Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide

Hospital or Attending Physician: The law requires that the death certificate be executed P.O. Box 68760, Division of Vital Records, nours after death.

neral Director: Ailled in by the fu 24 hours a

altimore, Maryland 21215-0036

within 24 hor To the Fune completely fi

State Registrar

0 31. Date filed (Month, Day,

29b. Signature and title of certifier

29a. Certifier



and manner stated

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29c. License number

29d. Date signed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygienery For State Registrar Certificate of Death Rea. No. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month 1:10 p.m. Kimme1 Paskow pri1 4a. Facility Name (if not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death St. Mary's Ridge 48618 Bonnie Lane 9. Birthplace (State or Foreign Country) New Jersey 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs 8. Date of Birth Days 1 X M 2 □ F Months Hours 06/11/1939 141-30-3001 Usual Residence of Decedent 10a. State 10b. County 10d. Inside City Limits 10c. City. Town or Location 1 Yes 2 X No Maryland St. Mary's Ridge 10f. Zip Code 10g. Citizen of What Country? 10e Street and Number 48618 Bonnie Lane 20680 United States 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14 Race - American Indian. 11. Marital Status Armed Forces?

1. Yes 2 No Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 XNo Specify: If Yes, Give Year or Dates Specify: 3 Widowed 4 Divorced White 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business Industry Elementary/Seconday (0-12) College (1-4 or 5+) Professor of Philosophy Education 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) David Paskow Celia Kimmel 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Jacqueline M. Paskow/Wife 48618 Bonnie Lane, Ridge, MD 20680 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date 1 Burial 2 X Cremation 3 Removal from State cemetery, crematory or other place, 4 ☐ Donation 5 ☐ Other (Specify) Brinsfield-Echols Cre 04/07/2011 Charlotte Hall, MD 22. Name and Address of Facility Brinsfield Funeral Home, P.A. Brinsfield Edward N. M0052 22955 Hollywood Road, Leonardtown, MD 20650 Interval Between Onset and Death 1/2 years.

Physician/ Medical Examiner

attending physician and for use as the burial-transit

signed by

page

After this

within 24 hours after death.

To the Funeral Director: A completed filled in by the fu

the Hospital or Attending Physician: The law requires that the death certificate be executed

Division of Vital Records, P.O. Box 68760

Physician/

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ral", or items 23a or 28a-f sho Examiner must be notified at

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permit. Page 1 and 2 should be filed within 72 hour Department of Health and Mental Hygiene. Important: If item 27 is marked other than "naturany injury or other traumatic event, the Medicall once.

filed within 72 hours after death with the Maryland

Baltimore, Maryland 21215-0036

Examiner cal

Part 1. Enter the disease, or complice shock, or heart failure. List only one	cations that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, cause on each line.	
nediate Cause (Final ease or condition ulting in death)	Metastatic Cancer Wely Ing primary. Due to (or as a consequence of):	
ny, leading to immediate se. Enter Underlying	Due to (or as a consequence of):	
use (Disease or iinjury Linitiated events c Linitiated events c	Due to (or as a consequence of):	•
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IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown 23c. If yes, outcome of pregnancy 1 Live Birth 2 Fetal death 3 Ectopic pregnancy 4 Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown						23d. Date of delivery Month Day Year
Dy P	Part II. Other significant conditions c	ontributing to death but not resulting in the	underlyir	ng cause given in Part I.		o use contribute to the cause of death? 2 \(\text{No} \) No \(3 \text{ \text{ Probably}} \) 4 \(\text{ Unknown} \)
completed					24a. Was an autopsy performed?	
Be (25. Was case referred to medical	25. Was case referred to medical 26. Place of Death (Check onli				
o R	examiner? 1 Yes 2 No	Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpati	ent 3 🗆	Othor		
Certificate;	27. Manner of Death Natural 5 Pending Accident Investigation Suicide 6 Could not be 4 Homicide determined		of M	28c. Injury at work? 1 Yes 2 No	28d. Describe how inj	jury occurred
		e 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)			28f. Location (Street and Number or Rural Route Number, City or Town, State)	
Medical	29a. Certifier (Check only one) 29a. Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Check only one) 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.					
	29b. Signature and title of certifier	2	29c. License number	29d. I	Date signed (Month, Day, Year)	
Nonah				DONAL	20 4	1-6-11

State Registrar 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Thrae Notch

Please Type or Print in Black Indelible Ink, Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene, 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Physician/ 0330 M 2011 <u>Lois Frances Parsons</u> Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death **Examiner** Salisbury Rehabilitation & Nursing Cto Dicomico Sbur If Under 24 Hrs 8. Date of Birth 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) If Under 1 Year **Funeral** Months Days (Month, Day, Year) 1 □ M 2 🛣 F Hours Min Country) **Director** MD 214-30-7736 Usual Residence of Decedent 28a-f shov 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Page 1 and 2 should be filed within 72 hours after death with the Maryland event, the Medical Examiner must be notified at Director 1 X Yes 2 No Fruitland MD Wicomico 10f. Zip Code ō 10e. Street and Number 10g. Citizen of What Country? than "natural", or items 23a Funeral 21826 USA 311 Morris Street 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status Armed Forces?

1 Yes 2 No Black, White, etc 1X Never Married 2 Married Completed by Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 X No Specify: SpB/Yack 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) permit. Page 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: If item 27 is marked other than any injury or other traumatic event, the Nonce. 11 Poultry Laborer Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Dorsey Smith Norman Parsons 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Truitt Street, Salisbury, MD 21801 Larry Parsons/Son 601 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date 1 Burial 2 Cremation 3 Removal from State cemetery, crematory or other place Crematory, 4-11-2011 Dover, DE 4 Donation 5 Other (Specify) 22. Name and Address of Facility 917 W. Isabella St. Bennie Smith Salisbury MD 21801 21. Signatury - Funeral Service Licenses MD 21801 Salisbury, Funeral Home 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ de lesa Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, Examiner cause. Enter Underlying Cause (Disease or iinjury To the Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery ☐ Ectopic pregnancy in the past 12 months?

1 Yes 2 No Pregnant at time of death Other (specify) within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the a completed filled in by the funeral director, page 2 should be detached it 9 Unknown g Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 2 No 3 Probably 4 Unknown 1 🗌 Yes 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 1 ☐ Yes 2 ☐ No 1 Yes 2 25. Was case referred to medical examiner? Be 26. Place of Death heck only one) 2 TNo 1 Yes ၉ 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 28c. Injury at work?
1 ☐ Yes 2 ☐ No 27. Manner of Death 28b. Time of Certificate: 28d. Describe how injury occurred 1 Natural 5 Pending Accident Investigation 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined Medical 1 🖵 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one 29b. Signature and title of certifie 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 21804

State Registrar 31. Date filed (Month, Day, Year)

M

1 - For State Registra

Physicia /Medica Examine

Funeral Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show amy injury or other traumatic event, it is the disches the provided of the disches a file of the disc

Baltimore, Maryland 21215-0036

Physician /Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Division of Vital Records, P.O. Box 68760,

	Registrar			Cei	rtilicate oi	Deam	Re	g. No.			
	1. Decedent's Name	e (First, Midd	le, Last)				2. Date of Death		3. Time of Death		
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al	An English Name (If not institution, give street and number)				4b. City, Town, or Location of Death 4c. County of E						
ier						roll					
	112 Carnival Drive 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday)					neytow			thplace (State or Foreign		
	217-64-		1 M 2 M F	55 Yrs.	If Under 1 Year Months Days	Hours Mi		1955 Co	NC		
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	10a. State	10b. County	/	10c. City, Town or Lo	ocation				10d. Inside City Limits		
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ect	MD 10e. Street and Nur		1011	Tane	10f. Zip Code		10	g. Citizen of What Co	ountry?		
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<u>ra</u>	112 Ca	rniva	l Drive								
nun	11. Marital Status		12. Was Decedent Armed Forces?	Ever in U.S. 13.	Was Decedent of I If Yes, specify Cub	Hispanic Origin? an, Mexican, Pu	(Specify Yes or No- erto Rican, etc.)	14. Race - Ame Black, White			
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To Be	John E.	Show	ers, Sr.			O. Cr	ristine_	Moser			
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	20a. Method of Disp			20b. Place of Dispo	osition (Name of	روز Apr	Date 2	0c. Location - City or	Town, State		
	1 XBurial 2 I 4 Donation		3 Removal from State	West Li	natory or other pla iberty	MÜ API		hite Hal	1 - MD		
	21. Signature of Fu		· · · · · · · · · · · · · · · · · · ·	Ceme	Etery 2. Name and Addr				tuary Inc.		
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ie.	Sequentially list cor if any, leading to im cause. Enter Unde Cause (Disease)	mediate	Due to (or as	a consequence of):							
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m	resulting in death) I	Last	Due to (or as	a consequence of):							
n/Medical Examiner			d								
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S							perform	No 1 ☐Ye	s 2 🗆 No		
Be	25. Was case reference examiner?	red to medica	Nacarital:				Death (Check only one				
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ü	27. Manner of Death	h 5 ∐ Pendir	28a. Date of Inju	ury 28b. Time o ay, Year) Injury	Wo		28d. Describe how	v injury occurred			
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ŧij	3 ☐ Suicide 4 ☐ Homicide	6 □ Could detern	nined 28e. Place of In	ury - At home, farm, str c. (Specify)	reet, factory, office		28f. Location (Str. City or Town,	eet and Number or Fi State)	tural Route Number,		
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Medical Certification: To	29a. Certifier (Check only (C										
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	30. Name and address of person who completed cause of death (Item 23a) (Type, Print) SCHSh A. Shah M.D. 544 204, 826 Washigh Rd Westman										
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State

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registral Certificate of Death Reg. No. 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month MARCH Year 2011 Physician/ 11:43 AM RIVERA-SANCHEZ Medical 4c. County of Death 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** FREDERICK MEMORIAL HOSPITAL FREDERICK FREDERICK If Under 1 Year If Under 24 Hrs. 8. Date of Birth g. Birthplace (State or Foreign Social Security Number 6. Sex 1 M 2 □ F 7. Age (In yrs. last birthday) **Funeral** (Month Day, Days Hours Min Puerto Rico Jun. 1968 582-61-6264 42 Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State must be notified at Director No Yes 2 ☐ No 28a-f Frederick MD Frederick 10f. Zip Code 10g, Citizen of What Country? 10e. Street and Number 23a Funeral USA 40068 Branca Dr. 21702 "natural", or items Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U. Armed Forces? 99–20 14. Race - American Indian, Black, White, etc. þ 1 Never Married 2 M Married Page 1 and 2 should be filed within 72 hours after or ment of Health and Mental Hygiene.
ant. If item 27 is marked other than "natural", or 1 X Yes 2 □ No Specify: Puerto Rican Maryland 21215-0036 If Yes, Give Year or Dates Completed 3 Widowed 4 Divorced Hispanic event, the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) College (1-4 or 5+) Elementary/Seconday (0-12) Soldier U.S. Army Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Virginia Sanchez Victor M. Rivera 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Frederick, MD Nancy Rivera / Wife 40068 Branca Dr., other 1 Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Department of F Important: If ite any Injury or ot once: 1X Burial 2 ☐ Cremation 3 X Removal from State Las Piedras, Puerto Rico 3/29/2011 4 ☐ Donation 5 ☐ Other (Specify) Caimito Del Mango 22. Name and Address of Facility Beall Funeral Home Signature of Ameril Service Licensee 6512 NW Crain Hwy., Bowie, MD 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Due to (or as a conse Examiner veumoni Sequentially list conditions, if any leading to immediate cause. Enter Underlying Cause (Disease or linjury Examiner Due to (or as a consequence of) that initiated events Due to (or as a consequence of): resulting in death) Last physician at the burial-t Certificate: To Be Completed by Physician/Medical Box 68760 as the IF FEMALE use 23c. If yes, outcome of pregnancy 1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ 1 Live Birth 2 Fetal deat
4 Pregnant at time of death
9 Unknown in the past 12 months? Year for Month Day signed by the a g 🗌 Unknown P.O. To the Hospital or Attending Physician: The law requires that the Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🎇 Unknown astric cancer Division of Vital Records. pluods 24b. Were autopsy findings available prior to completion of cause of death? autopsy performed 2 X N Yes 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 2 X No 1 X Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 27. Manner of Death 28b. Time of 28c. Injury at 28a. Date of injury 28d. Describe how injury occurred (Month, Day, Year) injury work? 1 ☐ Yes 2 ☐ No 5 Pending Accident Investigation 3 Suicide
4 Homicide 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined Medical (Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check eftifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one 29d. Date signed (Month. Day, Year, 29b. Signature 29c. License number MOD 65378 of person who completed cause of death (Item 23a) (Type, Print) 30 Name and addresa 400 W 7th St Frederick 31. Date filed (Moi State Registrar

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Redifer Month Grace Lorraine Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Praintil Medical Cento 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 🗆 M 2 🏝 F Months Days Min. 218-36-1779 Hours 05/27/1940 Maryland Director 70 Usual Residence of Decedent r than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 X No Maryland Wicomico Salisbury 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 132 Harford Road 21801 USA Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12 Was Decedent Ever in U.S. 14 Race - American Indian. Armed Forces?

1 Yes 2 X No
If Yes, Give
Year or Dates. Black, White, etc. þ 1 Never Married 2 Married filed within 72 hours after Maryland 21215-0036 1 Yes 2 X No Specify: Specify: 3 Widowed 4 Divorced white Completed 15. Decedent's Education 16a. Decedent's Usual Occupation 16h Kind of Business Industry (Specify only highest grade completed) Give kind of work done during most of working I Hygiene. life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Police Officer Law Enforcement 12 Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) and Mental should be Hollis Ward Hardesty Bessie Roberta Perrie Lege 1 and 2 sh.
Legerthent of Health and
Important: If item 27 is many injury or other 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 132 Harford Rd., Salisbury, MD 21801 Carlisle Redifer/spouse Baltimore. 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Burial 2 X Cremation 3 Removal from State Salisbury Crematory 3/30/2011 Salisbury, MD ☐ Donation 5 ☐ Other (Specify) Signature of Funeral Service Licensee Holloway Funeral Home Professional Association 501 Snow Hill Rd., Salisbury, MD 21804 Dompor 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line. Immediate Cause (Final Physician/ disease or condition resulting in death) Deritonit Medical Due to (or as a consequence of Examiner Sequentially list conditions Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of) the burial-transi that initiated events resulting in death) Last Due to (or as a consequence of): attending physician Physician/Medical certificate be Box 68760 been signed by the attending p should be detached for use as 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregna 5 Other (specify) Ectopic pregnancy in the past 12 months?

1 Yes 2 No
9 Unknown Year Pregnant at time of death Month Day P.0. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ MUIDIPLE mycloma 1 Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown of Vital Records, Completed COPO 24b. Were autopsy findings available prior to completion of cause of 24a. Was an page 2 s autopsy performed death? 1 Yes 2 No Yes 25. Was case referred to medical examiner? completed filled in by the funeral director, To Be 26. Place of Death (Check only one) Other: 1 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred To the Hospital or Attending within 24 hours after death.

To the Funeral Director: After 1 Natural 5 Pending Division 1 Yes 2 No Accident Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Medical Letrifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifier (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one 29d. Date signed (Month, Day, Year) of person who completed cause of death (Item 23a) (Type, Print) 30. Name and addre

Registrar
DHMH 17 Rev 7/2009

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygien ? State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) ISABELLA 2. Date of Death Physician/ MAR 10^{Day}2011 4:45 P M GRACE -ANN/ROBINSON Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner MONTGOMERY NATIONAL NAVAL MEDICAL CENTER BETHESDA 5. Social Security Number If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) 6. Sex 8. Date of Birth Age (In yrs. last birthday) **Funeral** Days (Month Day, Year) 201 1 M 2 X F 23^{Min} **Director** Usual Residence of Decedent 28a-f shov 10a. State 10b. County 10c. City, Town or Location 27 is marked other than "natural", or items 23a or 28a-f sho traumatic event, the Medical Examiner must be notified at 10d. Inside City Limits Director PRINCE WILLIAM QUANTICO VA1 Yes 2 No 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 11140 TUMMERMAN STREET 22134 US 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-11, Marital Status Was Deceden 2 Armed Forces? 14. Race - American Indian If Yes, specify Cuban, Mexican, Puerto Rican, etc. Black, White, etc. δ 1 X Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: If Yes, Give Year or Dates. Specify: BLACK Completed 3 Widowed 4 Divorced Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working and Mental Hygiene. life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) N/ABe 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ NYOKA ANTOINETTE DIAS PAUL ANTHONY ROBINSON permit. Page 1 and 2 should be Department of Health and Mer Important: If item 27 is marke any injury or other traumatic 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 11140 TUMMERMAN STREET QUANTICO CA 22134 PAUL A.ROBINSON/FATHER 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State ematory or other place ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 Donation 5 ☐ Other (Specify) APR 4 2011 21. Signature of Fundral Se 22. Name and Address of Facility NATIONAL NAVAL MEDICAL WISCONSIN AVE., BETHESDA MD Part 1. Enter the disease, or o implications that taked the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. 2088i9ate5600 Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) EXTREME PREMATURITY Medical Due to (or as a consequence of) Examiner Sequentially list conditions. if any, leading to immediate cause. Enter Underlying Cause Unisease or impury Due to (or as a consequence of) Exami Hospital or Attending Physician: The law requires that the death certificate be executed physician and s the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical attending p IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ ed by the atten detached for u in the past 12 months?

1 Yes 2 No Month Day Year Pregnant at time of death 9 Unknown 9 Unknown signed to Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Records, 1 ☐ Yes 2 🖾 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available 24a, Was an autopsy performed prior to completion of cause of death? page 24 hours after death.

Funeral Director; After this certificate I 2 🗌 No 1 🗌 Yes 25. Was case referred to medical completed filled in by the funeral director, Be 26. Place of Death (Check only one) Other: 1 🗌 Yes ပ္ 2 √ No 1 X Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b, Time of Certificate: 28c. Injury at 28d. Describe how injury occurred Natural 5 Pending 1 🗌 Yes 2 🗌 No Investigation 6 Could not be Accident 3 Suicide 4 Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier To the within 2 only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 0101245138 (VA) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) NATIONAL NAVAL MEDICAL CHINENYE ADIMORA CAPT mc USA BETHESDA MD 20889-5600 31. Date filed (Month, Day, Year) Registrar's Signature State Registrar

Box 68760

P.O.

Division of Vital

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygienery 1 - State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Physician/ Month 2:20 PM Ruppenthal Jr. 2011 Medical 4c. County of Death 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** oyalton Assisted Livine Hagerstown Washington If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign 5. Social Security Number 8. Date of Birth 6 Sex 7. Age (In yrs. last birthday) **Funeral** oct. 4 Days We\$t™Virginia Hours Min. **1**√**X** M 2 □ F 92 232-26-6384 Director Usual Residence of Decedent or 28a-f show e notified at 10d. Inside City Limits Page 1 and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene. In the Maryland fant. If Item 27 is marked other than "natural", or items 23a or 28a-f show ury or other traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location Director Berkeley Springs WV Morgan 1 ☐ Yes XX No 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number Completed by Funeral U.S.A. 25411 40 Venetian Lane 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes XX No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11, Marital Status Black, White, etc. 1 Never Married 2 Married 1 Yes If Yes, Give White Baltimore, Maryland 21215-0036 1 ☐ Yes XX No Specify: 3√Widowed 4 □ Divorced Year or Dates 16a. Decedent's Usual Occupation 16b. Kind of Business Industry Decedent's Education (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Sand mining Crane operator Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ဂ္ Johnson Maggie Ercel Buford Ruppenthal, Sr. 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 385 Sulphur Springs Rd., Inwood, WV 25428 Ercel B. Ruppenthal, III/Son 20c. Location - City or Town, State 20a. Method of Disposition XX Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (2017) 20b. Place of Disposition (Name of Snyr) on the place) permit. Page 1 a
Department of H
Important: If ite
any injury or ot 4/11/2011 Hedgesville, WV Church Cemetery Signature of Funeral Service Licensee Name and Address of Facility Helsley-Johnson FH & Cremation Center M00522 Berkeley Springs, WV 25411-1855 95 Union St. Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line Immediate Cause (Final Physician/ disease or condition resulting in death) ProState Medical Due to (or as a consequence of) Examiner Sequentially list conditions Examine Due to (or as a consequence of): if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury attending physician and for use as the burial-transit the Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months? Month Day Pregnant at time of death 4 ☐ Pregnant
9 ☐ Unknown Yes 2 No within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the s completed filled in by the funeral director, page 2 should be detached to 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy performed? Yes 2 N 1 Yes 2 No Be 25. Was case referred to medical 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 1 ☐ Yes 2 🗷 No 6 Sother (Specify) ASSISHED မ 1 Inpatient 2 ER/Outpatient 3 DOA Living 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate; Manner of Death 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 \square Pending work? 1 ☐ Yes 2 ☐ No Accident Investigation Suicide 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Homicide determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check 3 Scertifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number Smith CRIP 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 31. Date filed (Month, Day, Year)

DHMH 17 Rev 7/2009

State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ William Colbert March 30 2011 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c, County of Death Examiner Glen Burnie Anne Arundel Baltimore Washington Medical Cent 9. Birthplace (State or Foreign Country) Washington DC | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth | Months | Days | Hours | Min. | (Month, Day, Year) | October 29,1938 7. Age (In vrs. last birthday) Social Security Number 6. Sex → 1 A M 2 □ F **Funeral** 579-50-4115 Director Usual Residence of Decedent 10d. Inside City Limits 10c, City, Town or Location 10b. County 10a. State should be filed within 72 hours after death with the Maryland Director 3a or 28a-f sh t be notified a 1 ☐ Yes 2 No MD St. Mary's Callaway 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number ms 23a c must be Funeral 20620 USA 20285 Four Knotts Way Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. Black, White, etc. Armed Forces? 1 Never Married 2 Married "natural", or Completed by Maryland 21215-0036 White 1 Yes 2 XNo Specify: If Yes, Give Year or Dates Specify: 3 X Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) marked other than College (1-4 or 5+) Elementary/Seconday (0-12) permit. Page 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: If item 27 is marked other than any injury or other traumatic event, the Men injury or other traumatic event, the Men injury or other traumatic event, the Men injury or other traumatic event, the Men injury or other traumatic event, the Men injury or other traumatic event, the Mental Event injury or other traumatic event, the Mental Event injury or other traumatic event. 0iler DC Govt Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Marion Frances Bowie Colbert Scott 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a, Informant's Name/Relationship (Type, Print) Box 99, Callaway, MD 20620 Brenda Sue Knott/Daughter Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 X Burial 2 Cremation 3 Removal from State Old Durham Cemetery 4/4/2011 Ironsides, Maryland 4 Donation 5 Other (Specify) M00945 21. Sign vure of Funeral Service Licensee 22. AREHART ECHOLS FUNERAL HOME, PA. Muy Echi 20646 Ave 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between set and Death Immediate Cause (Final Physician disease or condition Medical resulting in death) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director, After this certificate has been along the control of the property of the control attending physician and for use as the burial-tran that initiated events resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IE FEMALE yes, outcome of pregnancy

Live Birth 2 Fetal death

Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No Month Day 1 ☐ Yes 2 ☐ Unknown been signed by the should be detached Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 1 🗌 Yes 2 🔲 No 2 No 26. Place of Death (Check only one) completed filled in by the funeral director, 25. Was case referred to medical Be examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA 2-No မ 28a. Date of injury 28b. Time of 28c. Injury at 28d. Describe how injury occurred 27. Manner of Death Certificate: (Month, Day, Year) injury work? 1 ☐ Yes 2 ☐ No 1 Natural 5 Pending 2 Accident 3 Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier

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State Registrar

(Check only one)

29b. Signature and title of certifier

31. Date filed (Month, Day, Ye

30. Name and address of person who completed car

se of death (Item 23a) (Type, Print)

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29d. Date signed (Month, Day, Year)

11-02673 Gary Sweda

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Series S	1	J	U	0

Gary Sweda	1- For State Certificate Certificate C		Reg. No.
Physician/ Medical Examine	1. Decedent's Name (First, Middle, Last) Gary Sweda	Mon	of Death 3. Time of Death
	4a. Facility Name (if not institution, give street and number) Baltimore Washington Medical Center	4b. City, Town, or Location of Death Glen Burnie	4c. County of Death Anne Arundel
Funeral Director	5. Social Security Number 216-66-3056 6. Sex 7. Age (In yrs. last birthday)	14 m 1 m 1 m 1 m 1 m 1	te of Birth(MM/DD/YYYY) 9. Birthplace (State or Foreign Maryland Country)
any	Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Loc		10d. Inside City Limits
the Maryland a or 28a-f show tiffed at once. Director	MD Anne Arundel Severna 10e. Street and Number	Park 10f. Zip Code	1 Yes 2 No
ith the M 23a or 2 notified		21146 Vas Decedent of Hispanic Origin? (Specify Ye	USA es or No- 14. Race - American Indian, Black,
Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours after death with the Maryland popartment of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show injury or other tranmatic event, the Medical Examiner must be notified at once. To Be Completed by Funeral Director	1 Never Married 2 Married Armed Forces? 1 Yes 2 No 1 Widowed 4 Divorced of Pales: 1	Yes, specify Cuban, Mexican, Puerto Rican, e Yes 2 X No specify:	white, etc. Specify: White
5-0036 ed within 72 hours tygiene. other than "natus the Medical Exam Completed	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) Pho	ent's Usual Occupation (Give kind of work don most of working life. DO NOT use retired) Dtographer	16b. Kind of Business/Industry Photography
21215-0036 uld be filed within ? Mental Hygiene. marked other than c event, the Medical To Be Comple	Joseph Sweda	18.Mother's Name (First, M Alvina Du	gan
MD 21 d 2 should d 2 should lth and Me n 27 is ma numatic er	Echele Heinbuch/ Companion 228	ng Address (Street and Number or Rural Ro B Ambleside Drive Seve	erna Park, MD 21146
Baltimore, permit. Pages I an Department of Heal Important: If iten injury or other tra	1 Runal 2 X Cremation 3 Removal from State crematory or c	position (Name of cemetery, other place) ematory, INC. Date April 1 201	20c. Location - City or Town, State Baltimore, MD
Balt permit. Depart Import injury	21. Signature of Funeral Service Licensee 22. B	Name and Address of Facility arranco & Sons, P.A. 95 Ritchie Hwy,	Severna Park Funeral Home Severna Park, MD 21146
Physician /Medical Examiner	23a. Part I. Equif II. disease, or complications that caused the death. Do not enter failure. List any one cause on each line. Immediate Cause (Final disease a. Atherosclerotic		atory arrest, shock, or heart Approximate Interval Between Onset and
	or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, b.		
red Insit Examiner	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of):		
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687 ertific ding p	past 12 months? 4 Pregnant at time of death 5	Fetal death 3 Ectopic pregnancy Other (Specify)	23d, Date of delivery Month Day Year
O. Box at the death of by the attenstacked for us	Part II. Other significant conditions contributing to death but not resulting in the	underlying cause given in Part I. 23	e. Did tobacco use contribute to the cause of death?
ords, P.O. w requires that the sheen signed by should be detach			Yes 2 No 3 Probably 4 ✓ Unknown a. Was an 24b. Were autopsy findings available
		1	autopsy prior to completion of cause of death? Yes 2 No 1 Yes 2 No
f Vital Physician or this certiral director	25. Was case referred to medical examiner? 1 ✓ Yes 2 No Hospital: 1 Inpatient 2 ✓ ER/Outpatien	26.Place of Death (Check only one of the 13 DOA Other Nursing Home	
Division of Vital To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certif completely filled in by the funeral director, edical Certification: To Be (27. Manner of Death 1 X Natural 5 Pending 2 Accident Investigation 28a. Date of Injury (Month, Day, Year) 28b. Time of Death (Month, Day, Year)	f Injury 28c. Injury at Work? 28d. De 1 Yes 2 No	escribe how injury occurred
E 2 2 2 2 3 2 3 3 3 3 3 3 3 3 3 3 3 3 3	3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, str		cation (Street and Number or Rural Route Number, City Town, State)
To the Howithin 24 h To the Fur completely	29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occ one) 2 Medical Examiner: On the basis of examination and/or investig and manner stated.		
	29b. Signature and title of certifier	29c. License number O.C.M.E.	29d. Date signed (Month, Day, Year) April 8, 2011
	30. Name and address of person who completed cause of death (Item 23a) Laron Locke MD. Assistant Medical Examiner 111 Pen	n Street, Baltimore, MD 21201	•
State Registrar	31. Date filed (Month, Day, Year) APR 1 2 2011 32. Registrar's Signature	uks	

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2301 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day 2<u>011</u> Physician/ Month M 31 1200 Luther Albert Shultz March Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 906 Loch Raven Road Salisbury Wicomico 9. Birthplace (State or Foreign Country)
PA 8. Date of Birth (Month, Day, Y)
July 23, 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs Social Security Number **Funeral** Hours Months 1 X M 2 - F Director 188-09-2194 92 Usual Residence of Decedent "natural", or items 23a or 28a-f show dical Examiner must be notified at 10a. State 10b. County 10d. Inside City Limits within 72 hours after death with the Maryland 10c. City, Town or Location Director 1 🗌 Yes 2 🛣 No MD Wicomico Salisbury 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21804 U.S.A. 906 Loch Raven Road 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Armed Forces?

1 🖾 Yes 2 🗆 No 1943— Black, White, etc. þ 1 Never Married 2 X Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify: If Yes, Give Year or Dates Specify: 3 Widowed 4 Divorced white Completed 1946 the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life, DO NOT use retired) College (1-4 or 5+) Elementary/Seconday (0-12) school teacher education of Health and Mental Hygier item 27 is marked other I other traumatic event, the Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) permit. Page 1 and 2 should be file Department of Health and Mental I Important: If item 27 is marked o any injury or other traumatic eve မ Albert George Shultz Maybelle Eitnier 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 21875 David Albert Shultz (Son) 303 S. Maryland Avenue Delmar, MD 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other place) 1 ☐ Burial 2 🖾 Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Delmarva 04-01-2011 of Delmar, Delaware rematory of Funeral Service Licensee 22. Name and Address of Facility Funeral Home Grove Street Short 13 E. Home Delmar. 23a. Part 1. Enter the g sease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between shock, or heart failure. List only one cause Onset and Death Immediate Cause (Final Ph_sician/ disease or condition resulting in death) Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury Examiner Due to (or as a consequence of): • Hospital or Attending Physician: The law requires that the death certificate be executed 24 hours after death. • Funeral Director: After this certificate has been signed by the attending abuses and as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: use 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy5 Other (specify) in the past 12 months?
1 Yes 2 No page 2 should be detached for Pregnant at time of death Month Day Year 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? δ 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy perform 1 🗌 Yes Yes completed filled in by the funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital: Other: No 🏹 ျပ 1 Inpatient 2 Inpatient 3 Inpatient 3 Inpatient 2 Inpatient 3 Inpatient 3 Inpatient 2 Inpatient 3 Inpatient 2 Inpatient 3 Inpatient 2 Inpatient 2 Inpatient 2 Inpatient 2 Inpatient 2 Inpatient 3 Inpatient 2 Inpatient 3 Inpatient 3 Inpatient 3 Inpatient 2 Inpatient 3 Inpa 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Feath 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred Natural 5 Pending 1 ☐ Yes 2 ☐ No ☐ Accident ☐ Sulcide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, ☐ Homicide determined City or Town, State Medical 29a. Certifier 🔀 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. To the within 2 To the only one 29d. Date signed (Month, Day, Year) 2gb

State Registrar

Name and address of person who co

31. Date filed (Month, Day, Year)

APR

pleted

2011

cause of death

Registrar's Signature

(Item 23a) (Type

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

		1 - State of Maryland / Department State of Maryland / Department State of Maryland / Department	g914,04/15/2011dh	b,20b per	#Q 12305	
Physic		Decedent's Name (First, Middle, Last) WILLIAM ROGER SOHNN		2. Date of Death Month MARCH	Day Year 9:00 P M	
Med Exam		4a. Facility Name (if not institution, give street and number) CIVISTA MEDICAL CENTER	4b. City, Town, or Location of Death LAPLATA		4c. County of Death CHARLES	
Funera Dírecto		5. Social Security Number 1 1 7 − 38 − 79 4 7 6. Sex 1 ☑ M 2 ☐ F 7. Age (In yrs. last birthday) 60 Yrs.	If Under 1 Year If Under 24 Hrs. Months Days Hours Min.	8. Date of Birth	9. Birthplace (State or Foreign 0 NEW YORK	
ryland -f show ied at	Director	Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Low			10d. Inside City Limits 1 ☐ Yes 2 [X]No	
the Ma a or 28a se notifi			10f. Zip Code	10g.	Citizen of What Country?	
ath with ems 23s	Funeral	9485 BLOSSOM POINT ROAD 11. Marital Status 12. Was Decedent Ever in U.S. 13. V	20693	cify Yes or No-	U. S. A.	
re, Maryland 21215-0036 1 and 2 should be filed within 72 hours after death with the Maryland f Health and Mental Hygiene. Item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at	þ	1 Never Married 2 Married 1 Yes 2 No	Was Decedent of Hispanic Origin? (Spef Yes, specify Cuban, Mexican, Puerto	Rican, etc.)	Black, White, etc. Specify: WHITE	
21215-0036 within 72 hours after giene. ier than "natural", o	Completed	15. Decedent's Education 16a. Deceder (Specify only highest grade completed) (Give in the interpretation of the interpretation) (Give in the interpretation of the interpretatio	dent's Usual Occupation kind of work done during most of worki O NOT use retired)	ing 16b.	. Kind of Business Industry	
d 212 ed withii Hygiene rther th	Be Co	12 FARM 17. Father's Name (First, Middle, Last)		F (First, Middle, Maide	ARMING	
Maryland 2 should be filed th and Mental Hy 27 is marked oth traumatic event	100			IA LOPIN	· ·	
nd 2 shoul ealth and m 27 is m			ng Address (Street and Number or Rura BLOSSOM PT. R	-		
Baltimore, permit. Page 1 and Department of Hed Important: If item any injury or othe		4 Donation 5 Other (Specify) NEWPORT	natory or other place) CEMETERY 04/0	6/2011 _{NE}	Location - City or Town, State WPORT, NEW YORK	
Ball permit Depar Impor any in		21. Sonatur of Funeral Service Licensee M0 0 6 4 1 5	Name and Address of FacilityRAY. 6635 WASHINGTON	MOND FUN AVE.,LA	L. SERVICE, P.A. PLATA, MD 20646	
Dhusisian	23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Coset and Death					
PhysicianMedicaExamine		disease or condition resulting in death) a. Due to (or as a consequence of):	leny Vicare			
Market No.		Sequentially list conditions, if any liceding to immediate the cause. Enter Underlying				
760 cate be executed physician and the burial-transit	Examiner	Cause (Disease or iinjury that initiated events resulting in death) Last C. Due to (or as a consequence of):				
760 ficate be e g physiciar ss the buria	dical	d	200			
Box 68 death certific he attending ed for use as	by Physician/Medical	FFEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown 1 □ Live Birth 2 □ Fetal death 3 □ 4 □ Pregnant at time of death 5 □ 9 □ Unknown	Ectopic pregnancy Other (specify)		23d. Date of delivery Month Day Year	
dS, P.O quires that the en signed by uld be detad	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of 1 yes 2 No 3 Probably 4 24a. Was an autopsy performed? performed? 1 yes 2 No 1 yes 2 No 1 yes 2 No 1 yes 2 No 1 yes 2 No 1 yes 2 No 1 yes 2 No 1 yes 2 No 1 yes 2 No 1 yes 2 No 1 yes 2 No 1 yes 2 No 1 No 1 yes 2 No 1 No 1 No 1 No 1 No 1 No 1 No 1 No					
Rec The law ate has	Completed			24a. Was an autopsy performed?	24b. Were autopsy findings available prior to completion of cause of death? No 1 □ Yes 2 □ No	
Vital ysician; s certific	To Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 ▼ No Hospital: 1 ☐ Inpatient 2 ▼ ER/Outpatien	26. Place of Death (Check		6 ☐ Other (Specify)	
Division of Vital To the Hospital or Attending Physiciam: within 24 hours after death. To the Funeral Director: After this certific completed filled in by the funeral director,	Certificate: 1	27. Manner of Death 1. Natural 5 Pending (Month, Day, Year) 2 Accident Investigation		28d. Describe how inj		
JIVISI al or Atte s after de I Directo d in by th		3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of Injury - At home, farm, streething building, etc. (Specify)	eet, factory, office	28f. Location (Street a City or Town, Sta	and Number or Rural Route Number, tte)	
29a. Certifier (Check only one) 3 Certifying Nurse Practioner. To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as the control of the cause only one of the cause of th						
To the With To the COTH		29b. Signature/and title of/certifier	29c. License number	29d. [Date signed (Month, Day, Year)	
4		30. Name and address person with complete lause of death (Item 23a) (Type, P	Avenue La l'eu	pe M.D	20646	
St Regist	ate rar	31. Date filed (Month, Day, Year) APR 15 2011 2. Registrar's Signature APR 15 2011	Kel			

SOHNN, WILLIAM # 476945

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Mowch 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Dav Physician/ BAYLISS GLARA THYLOR Year PM 4:10 03 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner University of Maryland Medical Center Baltimore If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 02/11/1947 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** 1 □ M 2 🕱 F Days Hours Director MARYLAND 214-46-4060 64 Usual Residence of Decedent or 28a-f show notified at 10a. State 10c. City, Town or Location 10d. Inside City Limits Director 1X Yes 2 □ No QUEEN ANNE'S MD CHURCH HILL 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ō "natural", or items 23a or Funeral 602 MAIN STREET UNITED STATES 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian. Armed Forces?

1 Yes 2 No
If Yes, Give
Year or Dates. o. Black, White, etc. þ 1 Never Married 2X Married permit. Page 1 and 2 should be filed within 72 hours after of Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify: Completed 3 Widowed 4 Divorced WHITE Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) traumatic event, the 12 BANK TELLER BANKING Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည DELSWORTH BAYLISS AGNES CRISEL 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) CHARLES TAYLOR / HUSBAND 602 MAIN STREET CHURCH HILL, MARYLAND 21623 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1X Burial 2 Cremation 3 Removal from State cemetery, crematory or other place) injury or 4 Donation 5 Other (Specify) HILL CEMETERY 04/06/2011 CHURCH HILL, MARYLAND CHURCH 22. Name and Address of Facility
FELLOWS, HELFENBEIN & NEWNA FUNERAL HOME,
130 SPEER ROAD CHESTERTOWN, MARYLAND 21620 Signature of Funeral Service Licensee 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final Physician/ Myocardial disease or condition resulting in death) In farction Medical Due to (or as a consequence of): Examiner Sequentially list conditions. Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of): attending physician and for use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical death certificate be Box 68760 as been signed by the attending p IF FEMALE: yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) in the past 12 months?

1 Yes 2 No Month Day Year Pregnant at time of death 1 ☐ Yes 2 № 9 ☐ Unknown 9 Unknown P.O. Part II. Other significant conditions contributing to death but not resulting In the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Hospital or Attending Physician: The law requires Records, 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy performed? Yes 2 N page death? 2 No Division of Vital 25. Was case referred to medical completed filled in by the funeral director, 26. Place of Death (Check only one) Be examiner? 2 No Other: 1 Yes ဂ 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury 28b. Time of Certificate: 28c. Injury at work? 28d. Describe how injury occurred thin 24 hours after death. the Funeral Director: After (Month, Day, Year) 1 Natural 5 \square Pending 1 Yes 2 No ☐ Accident Investigation 3 Suicide 4 Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifier (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) To the within To the 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) MD. P25629 March 74, 2011 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 10212 am or snelley Sahu Baltimore 5 Green St 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Physician/ **Taylor** Preston Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death **Examiner** Allegany Cumberland WMHS-RMC 9. Birthplace (State or Foreign Country) WV If Under 1 Year If Under 24 Hrs. Social Security Number 7. Age (In vrs. last birthday) 8. Date of Birth **Funeral** Days ^{Year} 9<u>45</u> Sep 7 1 M 2 F 232-68-8943 Director 65 Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department or Health and Mental Hygiene. Important: If item 27 is marked other than "--- any injury or other than "---10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director Cumberland MD Allegany 1 XYes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21502 USA 14901 N. Bel Air Drive SW 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Armed Forces' Black, White, etc. 1 Yes 2 No ğ 1 Never Married 2 Married 1 ☐ Yes 2 ☐ No Specify: 3 Widowed 4 Divorced white Completed Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Coal Miner Coal Mining Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Georgia (Mullenex) Taylor Clint Taylor 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 14901 N. Bel Air Dr. SW Cumberland MD 21502 Dianah Taylor wife 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State ☐ Burial 2 ☐ Fremation 3 ☐ Removal from State scarpelli Funeral Home, P.A. 4/5/2011 MD Cresaptown Donation 5 Other (Specify) ignature uneral Service L 22. Name an Scarpelli Funeral Home, PA 108 Virginia Avenue: Cumberland, MD 21502 or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Enter the disease Approximate Interval Between Onset and Death Part 1. Enter the disease or complication shock, or heart failure. List only one cause Immediate Cause (Final Pnysician/ recumuna disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, in a cause. Enter Underlying Cause (Disease or iinjury that initiated events Examine Due to for as a consequence of To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit Due to (or as a consequence of) resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE yes, outcome of pregnancy Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day Year Pregnant at time of death 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? ☐ Yes 2 ☐ No Hospital or Attending Physician: The 2 🗌 No 1 Yes 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? 2-1 No Other: 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA မ 4 Nursing Home 5 Residence 6 Other (Specify) . Date of injury (Month, Day, Year) Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: 1-X Natural 5 Pending 1 🗌 Yes Accident Suicide Investigation 24 hours after deat Funeral Director: 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) Homicide determined Medical 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one 29b. Signature and title of cet

Registrar

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

D0033280

CUMBERLAND

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Physician/ 05 Llwendolyn Racheal Twyman Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Western MD Regional Medical Center Allegany Cumberland Social Security Number 6. Sex Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** (Month, Day, Year) 1 - M 2 X F Months Days Hours Min Country) **Director** 235-15-8814 Apri] Keyser. Usual Residence of Decedent 28a-f shov 10a. State 10c. City, Town or Location 10d. Inside City Limits the Maryland at Director notified a 1 X Yes 2 No WV Mineral Keyser 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ō "natural", or items 23a o Funeral 542 Virginia Street 26726 72 hours after death Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian Armed Forces 1 X Never Married 2 Married þ 1 ☐ Yes If Yes, Give Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🔀 No Specify: Specify 3 Widowed 4 Divorced Completed Year or Dates Black Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Department of Health and Mental Hygiene. Important: If item 27 is marked other than 'any injury or other traumatic event, the Me Elementary/Seconday (0-12) Page 1 and 2 should be filed within ment of Health and Mental Hygiene. ant: If item 27 is marked other than College (1-4 or 5+) 12 Never employed Disabled Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Ronald Isaac Twyman, Sr. Wanda Lee Redman 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) WV 26726 <u> Wanda Lee Twyman/Mother</u> 549 Virginia Street Keyser, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State April 2011 1 X Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Potomac Memorial Gardens Keyser, WV 22. Name and Address of Facility Signature Service Smith Funeral Home 0 Keyser 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate shock, or heart failure. List only one cause on each line Interval Between Onset and Death Immediate Cause (Final Pnysician/ disease or condition resulting in death) Medical Examiner Sequentially list conditions. Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of) or Attending Physician: The law requires that the death certificate be executed use as the burial-transi and that initiated events resulting in death) Last Due to (or as a consequence of): physician Physician/Medical Box 68760 attending IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Por Month Year Day Pregnant at time of death 5 Other (specify) signed by the a Yes 2 X No 9 Unknown Unknown P.O. I Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Records, 1 🗌 Yes 2 No 3 Probably 4 Unknown Completed page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performe billarion certificate chronic Yes 2 No within 24 hours after death.

To the Funeral Director: After this certifics completed filled in by the funeral director, to Place of th (Check only one) Division of Vital Be 25. Was case referred to medical examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2-No မ Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred Natural 5 Pending 1 Yes 2 No Accident Investigation Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined To the Hospital Medical 1 🔏 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 = Certifying Nurse Practioner. To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of ceptilier 29d. Date signed (Month, Day, Year)

Registrar DHMH 17 Rev 7/2009

State

Registra 's Signature

517 E. Oldtown Road

Cumberland, MD

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Ranjithan, M.D.

31. Date filed (Month, Day,

72 2011

21502

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygienes For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2 Date of Death Physician/ March 27,2011 Sophie Volcjak 9:45 AMM Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** 757 Sunnyfield Lane Baltimore Anne Arundel 8. Date of Birth . Social Security Number g. Birthplace (State or Foreign Country) If Under 1 Year If Under 24 Hrs. **Funeral** Age (In vrs. last birthday) Davs Hours 1 - M 2 F 184-16-4708 89 1677671921 PA. **Director** Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important; If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at 10a. State 10c. City, Town or Location 10d. Inside City Limits Director Anne Arundel 1 🗆 Yes 2 🛣No Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21225 757 Sunnyfield Lane USA 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. Completed by 1 Never Married 2 Married 1 ☐ Yes 2 🔀 No If Yes, Give Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🔀 No Specify: Specify. White 3 ☐ Widowed 4 ☐ Divorced Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Administrative Secretary USF&G 10 Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) ည Rade Simerick Kathryn Milkovic 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Dane I. Volcjak Son 757 Sunnyfield Lane Baltimore, MD 21225 Method of Disposition

1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date Maryland Veteran's 03/30/2011 Crownsville,MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Fane Service Licer 22. Name and Address of Facility Hardesty Funeral Home P.A.Gambrills, MD 21054 Taos 23a. Part 1. Enter the desease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death DEMENTIA ALZKOIN Ph sician disease or condition Medical resulting in death) Examiner Se uentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury that initiated events Examine Due to (or as a consequence of) Hospital or Attending Physician; The law requires that the death certificate be executed attending physician and for use as the burial-transit Due to (or as a consequence of): resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery Live Birth 2 Li Fetal God.
Pregnant at time of death
Unknown 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months?
1 Yes 2 No Month Day Year n signed by the a lid be detached f 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of 24a. Was an After this certificate has autopsy perform death? 1 🗌 Yes 2 🔲 No Yes Be 25. Was case referred to medical 26. Place of Death (Check only one) Hospital 1 ☐ Yes 2 No Other: 은 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Certificate; 28d. Describe how injury occurred 1 Natural injury 5 Pending 1 Yes 2 No Director: / Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number 4 Homicide determined City or Town, State) 24 hours a Medical Ecertifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. within 2 To the F only one) 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month. Dav. Year)

State
Registrar

DHMH 17 Rev 7/2009

4600 Ritami

32. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

RAPULL PATEL

37111

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene-For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ :45 A M Helen F. Williams Medical Facility Name (if not institution, give street and number or Location of Death ounty of Death **Examiner** 5. Social Security Number | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth | Months | Days | Hours | Min. | Month, Day | Apr 23 6. Sex 9. Birthplace (State or Foreign **Funeral** 1 LM 2X F 1936 Maryland Apr Director 212-34-8698 74 Usual Residence of Decedent per it. Page 1 and 2 should be filed within 72 hours after death with the Maryland Degartment of Health and Mental Hygiene.

any injury or other trainment. 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 ☐ Yes 2X No Maryland Anne Arundel Hanover 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 7737 Harmons Rd. 21076 USA Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S 14. Race - American Indian, 11 Marital Status Armed Force Black, White, etc. ş 1 Never Married 2X Married Yes 2 No 1 ☐ Yes 2X☐ No Specify: If Yes, Give Specify: **Black** 3 Widowed 4 Divorced Completed Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) 12th College (1-4 or 5+) 1yr Account Technician Dept. of Defense Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 James Taylor Nancy Smith 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Joe Williams (Husband) 7737 Harmons Rd. Hanover, 21076 Md. 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place)
Maryland Veteran 20c. Location - City or Town, State Date 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 4-4-11 Crownsville, Md. 4 ☐ Donation 5 ☐ Other (Specify) Signature of Funeral Service Licenses Windar Recordess & Factors Mortuary, 821 West St. Annapolis, Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Onset and Death Immediate Cause (Final Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Dusito (or as a consequence oi) Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-transit Due to (or as a consequence of) resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?

1 Yes 2 No
9 Unknown Month Year Day Pregnant at time of death After this certificate has been signed by the funeral director, page 2 should be detached Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy death? 1 Yes 2 No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) 2 No Hospita 1 🗌 Yes 4 Nursing Home 5 Residence 6 Other (Specify) 욘 1 Donatient 2 ER/Outpatient 3 DOA Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 1 Natural 28c. Injury at 28d. Describe how injury occurred Certificate: 5 Pending iniury work? 1 ☐ Yes 2 ☐ No n 24 hours after death.

The Funeral Director: All objected filled in by the funeral places. Accident Suicide Investigation 3 ☐ Suicide 4 ☐ Homicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) Medical 29a. Certifier 🔽 Certifying Physícian: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. only one) 29b. Signature and title of certif 29c. License number completed cause of death (Item 23a) (Type, Print) 30. Name and address of person

DHMH 17 Rev 7/2009

State Registrar

31. Date filed (Month, Day, Year

1121A

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiener Certificate of Death Rea. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Christopher Whitesel March 2011 5:31 P M Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Annapolis Anne Arundel Anne Arundel Medical Center Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Oct. 10, 1955 9. Birthplace (State or Foreign Country)DISTRICT Of Columbia 7. Age (In yrs. last birthday) **Funeral** 1 🔀 M 2 🗆 F Days 212-68-1244 55 Months Hours Min. **Director** Usual Residence of Decedent of Health and Mental Hygiene. Item 27 Is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director MD Anne Arundel Arnold 1 🗆 Yes 2 🔀 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21012 1454 Grandview Road USA Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian Armed Forces?

1 Yes 2 XNo Black, White, etc. þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 White 1 ☐ Yes 2 XNo Specify: If Yes, Give Year or Dates Completed 3 Widowed 4 Divorced 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Bartender Restaurant Be 17. Father's Name (First, Middle, Last, 18. Mother's Name (First, Middle, Maiden Surname) Should be file and Mental H Roy T. Whitesel Betty Ray Ashby 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 sh Department of Heatth ar Important: If item 27 is any injury or other trau 1454 Grandview Road Arnold, MD 21012 Kathleen P. Whitesel/ 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State March 29 1
Burial 2
Cremation 3
Removal from State Baltimore, MD Metro Crematory, INC. 2011 4 Donation 5 Other (Specify) 21. Signature of Funeral Service Licensee Barranco & Sons, P.A. Severna Park Funeral Home 495 Ritchie Hwy, Severna Park, MD 21146 Severna Park, 23a. P 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, s' ock, or heart failure. List only one cause on each line. Approximate Onset and Death Immediate Cause (Final Metastatic Physician/ Cancer disease or condition resulting in death) Medical Due to (or as a consequence of): **Examiner** Cancer TROWS Laryngea Sequentially list conditions Examine Due to for as a nonsectional it any, leading to infinedia cause. Enter Underlying requires that the death certificate be executed Cause (Disease or linjury attending physician and for use as the burial-trans that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Month 5 Other (specify) Day Year signed by the a d be detached f 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🗹 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a. Was an performed certificate funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 🗌 Yes 2 2 🔀 No 1 N Inpatient 2 ER/Outpatient 3 DOA this 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred To the Hospital or Attending 1 Matural 5 Pending I hours after death.
uneral Director: After 1 Yes 2 No Investigation 6 Could not be Accident Suicide 3 ☐ Suicide 4 ☐ Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined within 24 hours a To the Funeral C Medical 🖺 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check 3 🗆 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of pertifier 29c, License number 29d. Date signed (Month, Day, Year) Buch. D46052 28/11 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Porhway and follow Mo

Registrar DHMH 17 Rev 7/2009

State

31. Date filed (Month, Day, Year)

MAR 3 0 201

Box 68760

P.O.

Records,

Division of Vital

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene, For State Registrar Certificate of Death 1 Decedent's Name (First Middle | ast) 2. Date of Death 2^P/₂ 2011 Year Physician/ Mayoth 3:52 Рм Kasmir W. Witkiewicz Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Anne Arundel Anne Arundel Medical Center Annapolis If Under 1 Year If Under 24 Hrs. Social Security Number 9. Birthplace (State or Foreign 8. Date of Birth 7. Age (In vrs. last birthday) Funeral (Month, Day, Ye 1 XM 2 🗆 Hours New Jersey 91 1920 Director 149-07-9532 Usual Residence of Decedent 28a-f show 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Examiner must be notified at Director Anne Arundel Crofton 1 Yes 2 No MD 0 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 23a Funeral USA 21114 1558 Bandury Ct. items 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces?

1 XYes 2 No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black, White, etc. "natural", or ģ 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 X No Specify Specify: White Completed 3 X Widowed 4 ☐ Divorced Year or Dates. WWII traumatic event, the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) and Mental Hygiene. College (1-4 or 5+) 5+ Elementary/Seconday (0-12) Mechanical Engineer NASA Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ဂ Natalie Trez Joseph Witkiewicz 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 st Department of Health a Important: If item 27 is 58A Riverside Dr., William J. Lewandowski/Nephew Severna Park, MD Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 1 X Burial 2 Cremation 3 Removal from State injury or 4 Donation 5 Other (Specify) Resurrection Cemetery 3/31/2011 Clinton, MD 22. Name and Address of Facility Beall Funeral Home 'n 6512 NW Crain Hwy., Bowie, MD Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Priysician/ m disease or condition Medical resulting in death) Due to (or as a consequence of): **Examiner** Sequentially list conditions Examiner Due to or as a consumence of burial-transit Cause (Disease or iinjury that initiated events Hospital or Attending Physician; The law requires that the death certificate be executed Due to (or as a consequence of): resulting in death) Last attending physician for use as the burial Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) in the past 12 months? 4 Pregnant at time of death 9 Unknown Month Day Year signed by the a Yes 2 No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Winknown cate has been sig page 2 should b Completed neumoula 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 1515 2 🗌 No Yes 25. Was case referre 4 to medical Be 26. Place of Death (Check only one) Hospital: Other: 2 DXNo မ 1 Tyes 1 Inpatient 2 I ER/Outpatient 3 I DOA 4 Nursing Home 5 Residence 6 Other (Specify) After this 27. Manner of Death Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred injury 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No within 24 hours after death.

To the Funeral Director: All completed filled in by the fu 2 Accident Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State Medical 1 Seartifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one) 29b. Signature and title of certifier 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

State Registrar obe+ 1

strar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene, Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month 3 Physician/ 11:35 PM Margaret Wells Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death **Examiner** Salisbur WICOMICO Hospice at the 8. Date of Birth (Month, Day, 11/18/ If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) 7. Age (In vrs. last birthday) **Funeral** 1 ☐ M 2 💢 🖹 Hours 213-38-5911 Director 1940 Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at 10a. State 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 X No MD Worcester Berlin 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral Cape May Place 21811 USA 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S 14. Race - American Indian, 11 Marital Status Armed Forces Black, White, etc. 1 ☐ Yes 2 🛣 No If Yes, Give þ 1 Never Married 2 XMarried 1 Yes 2 No Specify: Specify: Completed 3 Widowed 4 Divorced white Year or Dates 16a. Decedent's Usual Occupation 15. Decedent's Education 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Accounting <u>Accountant</u> Be Baltimore, Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 Thomas A. Reilly Dorothy I. Meade aret 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Robert Wells / husband Cape May Place, Berlin, MD 21811 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ☑ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) First State Crem. 4/1/2011 Millsboro, DE 21. Signatur f Fire ral Service Licensee 22. Name and Address of Facility Burbage Funeral Home MSOV William St., Berlin, MD 21811 108 23a. Part 1 Enter the disease, or complications that caused shock, or beart failure. List only one cause on each line. e disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) MRLANDACA Physician, MRTASTATIC Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Examine Due to (or as a consequence of): Hospital or Attending Physician: The law requires that the death certificate be executed signed by the attending physician and dbe detached for use as the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of) by Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant Ectopic pregnancy in the past 12 months?

1 Yes 2 No
9 Unknown Month Other (specify) Pregnant at time of death 9 | Hnknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 PNo 3 Probably 4 Unknown Completed within 24 hours after death.

To the Funeral Director: After this certificate has been 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy performed 1 ☐ Yes 2 ☐ No 25. Was case referred to medical examiner?
1 ☐ Yes ☐ No funeral director, 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital မှ HOSPICE 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certificate: 27, Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Matural (injury 5 Pending 2 🗌 No 1 Yes Accident Investigation 6 Could not be Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated only one ertifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated d title of certifie 29b. Signature ar D0058410 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) SAUSBURY WS 21802 BA 10 6 Hursy WA 31. Date filed (Month, Day, Year) State

DHMH 17 Rev 7/2009

Registrar

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Amend 24a per med cert
State of Maryland / Department of Health and Mental Hygie 1 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Month Year Physician Lila Frances Williams 27 6:45 PM 2011 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City. Town, or Location of Death Examiner rincess Anne Somerset 31062 McCormick Swamp Road Princess 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) **Funeral** 1□M **2**0F Days Hours Min. 91 Director 218-20-5019 Usual Residence of Decedent 9-21-1919 MD with the Maryland 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits or 28a-f ehow other traumatic event, the Medical Examiner must be notified at 1 ☐ Yes 2 ☐ No Director Somerset Princess Anne MD 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Items 23a permit. Pages I and 2 should be filed within 72 hours after death v Department of Heelth and Mental Hygiene.

Important: If Item 27 is marked other then "natural", or Items 23a any injury or other traumatic event, the Medical Exercises 2008. McCormick Swamp Road 21853 USA 31062 Funerai 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, Black, White, etc. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 Never Married 2 Married 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: Baltimore, Maryland 21215-0036 1 Yes 2 No SpecifBlack Completed by 3 XWidowed 4 □ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Shore Up -Elementary/Secondary (0-12) College (1-4or 5+) Foster Grandmother Headstart 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Mary Hayward Joseph Corbin 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1 2 1 7 ADT 3 Shawnte Williams/Grandaughter 1629 Gwynn Parkway, Baltimore, Falls 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 ☐ Cremation 3 ☐ Removal from State Oaksville 4 ☐ Donation 5 ☐ Other (Specify) 4-2-2011 St. Marks Cem Princess Anne, MD 21. Signature of Funeral Service Licensee Bennie Smith 917 W. Isabella St. Salisbury, MD 21801 Funeral Home 23a. Part1. Enter the disease, or complications the shock, or heart failure. List only one cause caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events.) Due to (or as a consequence of): Examiner The law requires that the death certificate be executed use as the burial-transit that initiated events resulting in death) Last and Due to (or as a consequence of) attending physicien for use as the buria Box 68760 Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Dav Year 4☐Pregnant at time of death 5 Other (specify) P.O. been signed by the a should be detached to 9 Unknown 9 Hinknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, Completed by 1 ☐ Yes 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an autopsy performed? certificate 2X No 1 ☐ Yes 2 ☐ No 1 ☐ Yes Attending Physician: Be 25. Was case referred to medical examiner? 26. Place of Death Check only one Other: 4 Nursing Home Residence 6 Other (Specify) Hospital: 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To this After thi 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 28d. Describe how injury occurred Injury at Work? 28c. 1_Natural 5 Pending investigation death. 1 Yes 2 No within 24 hours after death To the Funerel Director: completely filled in by the f 2 Accident 6 Could not be determined 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 | Homicide ŏ Certifying Physician: To the best of my knowledge, death accurred at the time, data and place, and due to the nause(s) and in anher as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medicai (Check only one) To the 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 31/11 20059931 ho completed cause of death (Item 23a) (Type, Print) Rd Vernon 31. Date filed (Month, Day, Year) 32. Registrar's Signature State MAR 2011 Registrar

ORIGINAL

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month 03 Clarinda N. White 2:35 PM Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death Wicomico Salisbury atthe Social Security Number If Under 1 Year If Under 24 Hrs **Funeral** 6. Sex . Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign Months 1 M 2 XF Aug. 23, Year 1953 Hours 57 Director 215-62-1367 Usual Residence of Deceden an "natural", or items 23a or 28a-f shov Medical Examiner must be notified at 10a. State 10b. County death with the Maryland 10c. City, Town or Location 10d. Inside City Limits Director MD Wicomico 1 Tes 2 X No Salisbury 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral USA 21801 1808 Thomas Lane 12. Was Decedent Ever in U.S Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian Black, White, etc. þ Page 1 and 2 should be filed within 72 hours after went of Health and Mental Hygiene.
ant: If item 27 is marked other than "natural", or 1 Never Married 2 Married 1 Yes : 2 X No Maryland 21215-0036 Specify: Black 1 ☐ Yes 2 X No Specify: Completed 3 Widowed 4 Divorced Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) Wicanico County Board Elementary/Seconday (0-12) College (1-4 or 5+) 5+ Media Specialist Teacher Of Education Department of Health and Mental Hygi Important: If item 27 is marked other any injury or other traumatic event, i Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Christine Smith Allen Price 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Alonzo "Dickie" White/ Husband 1808 Thomas Lane - Salisbury, Maryland 21801 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 🖾 Burial 2 🗆 Cremation 3 🗆 Removal from State cemetery, crematory or other place, April 2, 2011 Venton, Maryland 4 Donation 5 Other (Specify) Trinity UMOVC Cemetery permit. 21. Signatur of Funeral Service Licenses 22. Name and Address of Facility Salisbury, Maryland Jolley Memorial Chapel - 1213 Jersey Road 21801 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Immediate Cause (Final Onset and Death ≱πysician/ disease or condition resulting in death) MALIG NAN COLUN CARCINDIN Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Errer Underlying Cause (Disease or iinjury Examine Due to (or as a consequence of) the burial-transi that initiated events resulting in death) Last Due to (or as a consequence of). attending physician Physician/Medical To the Hospital or Attending Physician: The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 as IF FEMALE 23c. If yes, outcome of pregnancy 1 Live Birth 2 Live Beath 23b. Was decedent pregnant 23d Date of delivery ☐ Live Birth 2 ☐ reca. ☐ Pregnant at time of death 3 Ectopic pregnancy
5 Other (specify) in the past 12 months? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autonsy Yes 1 L Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) 1 Yes Other: ည 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence (6 ☐ HOSPICA 27. Manner of Death I Director: After to d in by the funera Certificate: Natural 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 5 Pending work?
1 Yes 2 🗌 No Accident Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number. 4 Homicide City or Town, State) 24 hours Funeral leted filled Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check 🏿 🗆 Certifying Nurse Practioner. To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifie 29d. Date signed (Month, Day, Year) 1)0058410 5 mp 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 2/807 Registrar's Signatu State

DHMH 17 Rev 7/2009

Registrar

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death 2150M Ear1 William Wyand 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Medical Hagerstown Meritus Center Washington 5. Social Security Number . Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign Min. (Month, Day, Year) April 25. Country)
Marvland Months Days Hours 220-34-0158 1938 Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d Inside City Limits 1 Yes 2 No Berkeley Falling Waters 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 23 Mesa Drive 25419 U.S.A. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian. Armed Forces?
1 ☐ Yes 2 No 1 Never Married 2 Married 1 Yes 2 No Specify: If Yes Give Specify: 3 Widowed 4 Divorced White Year or Dates. 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business Industry Elementary/Seconday (0-12) College (1-4 or 5+) 12 Operator Livery Service 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Carl S. Wyand, Sr. Edith Welty 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mesa Drive, Falling Waters, WV 25419 Delores C. Wyand / Spouse 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 🕷 Burial 2 🗌 Cremation 3 🔲 Removal from State 4 Donation 5 Other (Specify) Rest Haven Cemetery 4/9/2011 Hagerstown, Maryland 22. Name and Address of Facility 21. Signature of Funeral Service Lice Rest Haven Funeral Chapel 1601 Hagerstown, Pennsylvania Ave., 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shock, or heart failure. List only one cause Immediate Cause (Final Heute disease or condition resulting in death) Due to (or as a consequence of): Due to (or as a consequence of)

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within 24 hours after death.

To the Funeral Director: After thi completed filled in by the funeral to

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þ signed t Physician/Medical

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Completed

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Certificate:

Medical

IF FEMALE:

death certificate be executed

Box 68760

P.O.

Division of Vital Records,

To the Hospital or Attending Physician: The law requires

Physician/

Examiner

Funeral

Director

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permit. Page 1 and 2 sh Department of Health a Important: If item 27 is

injury (

72 hours after death

Maryland 21215-0036

Baltimore,

event, the Medical Examiner must be

Director

Funeral

Completed by

Be

Medical

10a. State

WV

Sequentially list conditions. if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events resulting in death) Last

23b. Was decedent pregnant

Unknown

examiner?

Suicide

Homicide

in the past 12 months?

2 No

Due to as a consequence of):

23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 3 Ectopic pregnancy Pregnant at time of death 5 Other (specify) a
Unknown

23d. Date of delivery Month

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

1 🗌 Yes 2 No 3 Probably 4 Unknown 24a. Was an autopsy performe

24b. Were autopsy findings available prior to completion of cause of death? 1 Yes 2 No

Year

25. Was case referred to medical 26. Place of Death (Check only one) Other: 4 \(\triangle \) Nursing Home \(5 \) Residence \(6 \) Other (Specify) 2 No Inpatient 2 🗆 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred 5 Pending work? 1 ☐ Yes 2 ☐ No 1 Natural Accident

Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined

28f. Location (Street and Number or Rural Route Number, City or Town, State)

🗹 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check 3 🗆 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of 29c. License number

23e. Did tobacco use contribute to the cause of death?

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

 Date filed (Month, Day, Year) 32. Registra

State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death A Pri Physician/ Sr. M. Brian Anderson, RSM 30 P Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Saint Joseph Center Medica 70 WSON **Funeral** If Under 1 Year If Under 24 Hrs Birthplace (State or Foreign Country) Age (In yrs. last birthday) 8. Date of Birth 256-24-6299 1 □ M 2 🛣 F 2-19-1924 87 Director GA Usual Residence of Decedent 28a-f show 10c. City. Town or Location 10d. Inside City Limits injury or other traumatic event, the Medical Examiner must be notified at Director Baltimore 1 Yes 2 No Baltimore 10e. Street and Number ò 10f. Zip Code 10a. Citizen of What Country? Funeral 6806 Bellona Avenue 21212 USA 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status 14. Race - American Indian o þ 1 Never Married 2 Married 1 Yes 2 No If Yes, Give Page 1 and 2 should be filed within 72 hours after Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: "natural", Specify: White Completed 3 Widowed 4 Divorced Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) permit. Page 1 and 2 should be filed within 7 Department of Health and Mental Hygiene. Important: If item 27 is marked other than any injury or other traumetr. Elementary/Seconday (0-12) College (1-4 or 5+) Nursing Administration Religious Community Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Allen J. Anderson Odessa Whitley Anderson 19a. Informant's Name/Relationship (Type, Print) Religious 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Sisters of Mercy-Order 101 Mercy Drive, Belmont NC 28012-2898 20b. Place of Disposition (Name of 20c. Location - City or Town, State woodlawn Cemetery 4-27-11 1 X Burial 2 Cremation 3 Removal from State Woodlawn, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Bradley-Ashton Funeral 2134 Willow Spring Road, 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line Immediate Cause (Final Onset and Death Ph sician/ Sepsis Mrinary Tract Infection a. Severe Medical resulting in death) Examiner Gauss stially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events resulting in death) Last Exami Severe Metabolic Acidosis Physician/Medical Encephalopathy Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months?
1 ☐ Yes 2 X No Month Pregnant at time of death Unknown signed by the a g 🗌 Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Diabetes Mellitus Records, 1 Yes 2 No 3 Probably 4 Unknown Covenary Artery Disease 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy Atrial Fibrillation 1 ☐ Yes 2 ☐ No Yes 2 XN Division of Vital To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certific completed filled in by the funeral director, 25. Was case referred to medical examiner? 26. Place of Death (Check only one) 2 X No 1 Yes Other: 은 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 5 Pending injury 1 Yes 2 No Accident Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, Medical 🔀 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check 🗆 Certifying Nurse Practioner, To the best of myknowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 56030 Name and address of person who completed cause of death (Item 23a) (Type, Print) 7601 Osler Drive; Towson M.D. KoKota 31. Date filed (Month, Day, Year) State

DHMH 17 Rev 7/2009

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Reg. No. Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Year **Physician** OOIL AM Ohn Alawat 2011 C. Apri 15 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Johns Hopkins Bayview Medical Center Baltimore 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex **Funeral** Months Days Hours 1**X** M 2□ F 6-2-1943 67 235-68-8798 WV Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County or 28a-f show other traumatic event, the Medical Examiner must be notified at 1 Yes 2 No MD Baltimore Director Dundalk 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code Pages 1 and 2 should be filed within 72 hours after death with nent of Health and Mental Hygiene. 209 Riverview Avenue or items 23a 21222 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ▼No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify Specify: White þ 3 Widowed 4 Divorced Year or Dates: Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) of Health and Mental Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) 12 Bethlehem Steel Supervisor 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Lee Alawat ည <u>Mary Messaris</u> 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 5679 Phelps Luck Dr., Columbia, MD 21045 Kristy Obregon - Daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition permit. Pages
Department of
Important: If it
any injury or o 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Atlantic Crematory 4-16-11 Glen Burnie, MD 22. Name and Address of Facility 21. Signature of Funeral Service Licensee Bradley-Ashton Funeral Home, PA 2134 Willow Spring Road 21222 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Ischemic (ardiomyopath 4 hours /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) To the Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of): Box 68760, Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 | Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 5 ☐ Other (specify) P.0. 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, Completed by 1 Yes 2 No 3 Probably 4 Nonknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed ves 2 No 25. Was case referred to medical Be 26. Place of Death (Check only one) 1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA Medical Certification: To Date of Injury (Month, Day, Year) 28b. Time of 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 ☐ Pending investigation 1 □Yes 2 □ No within 24 hours after death.

To the Funeral Director: A completely filled in by the fu 2 Accident 6 ☐ Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 Homicide 1 🗹 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month. Dav. Year) 1165 Res -000 3 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 4940 Eastern Avenue Baltimore, MD 21224

Registrar

State

1/8/2014 Year)

32. Registrar's Signature

State Registrar 29b. Signature and title of certifier

30. Name and address of person Jenuit

31. Date filed (Month, Day, Year)

18

. Registrar's Signatur

29c. License number

FC2153391

the completed cause of death (Item 23a) (Type, Print) 7 do water Calone Drive #1/A + Clark Mb 2007 7 do water Calone

29d. Date signed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygien (Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month 4 Day DYAM 4c. County of Death 4a. Facility Name (If not institution, give street and number)
CHENEGES SEVENUL PANK 27TY WHILLIAM 4b. City, Town, or Location of Death vunde MD Severna Park. mnet If Under 1 Year | If Under 24 Hrs.

Months Days Hours Min. Birthplace (State or Foreign Country) Date of Birth (Month, Day, Year) 5. Social Security Number 7. Age (In vrs. last birthday) 6. Sex 1□M 2**X**F 9/3/1928 24 82 214 7827 MD Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10b. County 1 ☐ Yes 2 No Anne Arundel Pasadena MD 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 21122 U.S.A. 8431 Bay Drive Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 X No Specify: Specify: White 3 X Widowed 4 ☐ Divorced Year or Dates 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Cafeteria Manager Food Service 10 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) John Paul Seidl Cecelia Pfister 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 113 Bar Harbor Rd. Pasadena, MD 21122 Charles Stylc -Son 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 ☐ Cremation 3 ☐ Removal from State 4/14/11 Elkridge, MD Meadowridge Mem Pk 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility GJ Gonce Funeral Home 21. Signature of Euroeral Sovice Licensee e, PA 21122 Drive Pasadena, MD 169 Riviera 23a. Part 1. Enfer the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Due to (or as consequence of): Westerfeld to (or as a consequence of): Due to (or as a consequence of) IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months?
1 □ Yes 2 □ No 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 3 Ectopic pregnancy Year Month Day 5 Other (specify) 9 Unknow 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 Monknown

Physician /Medical Examiner

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certificate

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Division of Vital Records,

Attending Physician:

Physician /Medical

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Funeral

Director

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permit. Pages 1 and 2 to Department of Health an Important: If item 27 is any injury or other trau

Baltimore, Maryland 21215-0036

the Medical Examiner must be notified at

Director

Funeral

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Completed

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Equantistic productions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine Physician/Medical

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Hospital:

24a. Was an autopsy 1 □Yes 2 No

26. Place of Death (Check only one)

24b. Were autopsy findings available prior to completion of cause of death?
1 □Yes 2♥No

25. Was case referred to medical examiner? 2 No 1 ☐ Yes

27. Manner of Doath 1 Natural 2 ☐ Accident

5 ☐ Pending investigation 6 ☐ Could not be determined 4 Homicide

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28b. Time of 28a. Date of Injury (Month, Day, Year) Injury

Other: Nursing Home 5 Residence 6 Other (Specify) 28c. Injury at Work? 1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

29a. Certifier

3 Suicide

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

29c. License number

29d. Date signed (Month, Day, Year)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

30 Name and address of person who completed cause of death (Item 23a) (Type, Print)

JENNIETH CEANEMD, 2007 Ticlewater Calony Drive #1A, Annayales, Mp 249 CCarumn

State Registrar 31. Date filed (Month

gistrar's Signature

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State
Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 05 James W. Brooks Medical 4b. City, Town, or Location of Death 4a. Facility Name (if not institution, give street and number 4c. County of Death **Examiner** HIMOTE N/A (In yrs. last birthday) if Under 1 Year If Under 24 Hrs 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 06/20/1955 1 🗷 M 2 🗆 F 213-92-2789 <u>Maryl</u>and Director Usual Residence of Decedent 28a-f shov 10b. County 10c. City, Town or Location 10d. Inside City Limits permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho any injury or other traumatic event, the Medical Examiner must be notified at 10a, State Director Baltimore 1 Yes 2 No N/A MD 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? Funeral United States 21223 1909 Wilhelm Street Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, 11 Marital Status Black, White, etc. White Armed Forces 2 1 XNever Married 2 Married X Yes 2 No 1 ☐ Yes 2 X No Specify: Specify: If Yes, Give Completed 3 Widowed 4 Divorced Year or Dates 16a Decedent's Usual Occupation 15 Decedent's Education 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Disabled Disabled 12 Be Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Shirley F. Cramblett James F. Brooks 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code, 1909 Wilhelm Street, Baltimore, Maryland 21223 Peggy Brooks (Sister) Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State □ Burial 2 X Cremation 3 □ Removal from State 04/18/2011 Baltimore, Maryland Bayview Crematory 4 ☐ Donation 5 ☐ Other (Specify) ture of Funeral Service License 1. Sign 22. Name and Address of Facility Hubbard Funeral Home, Inc. 4107 Wilkens Avenue, Baltimore, Maryland 21229 23a, Part 1, Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest Approximate Interval Between shock, or heart failure. List only one cause on each line. Immediate Cause (Final Pnysician/ disease or condition resulting in death) Medical to (or as a consequence of) Examiner Sequentially list conditions Examiner if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of): Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or iinjury attending physician and for use as the burial-tran that initiated events by Physician/Medical Division of Vital Records, P.O. Box 68760 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Month 5 Other (specify) Pregnant at time of death Yes 4 ☐ Pregnant 9 ☐ Unknown signed by the all 1 ☐ Yes 2 L 9 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 No 1 🗌 Yes 3 ☐ Probably 4 ☐ Unknown Completed After this certificate has been 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy perform death? 1 Yes 2 No 1 Yes 2 No 25. Was case referred to medical examiner? funeral director, 26. Place of Death (Check only one) Be 2 1 No Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA 1 Tes 잍 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: work? injury Natural 5 Pending 2 🗌 No Investigation after death Accident completed filled in by the 3 ☐ Suicide 4 ☐ Homicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 24 hours a Medical 1 Vertifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a, Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check

State Registrar

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31. Date filed (MoNh, Day, Year)

APR 18 2011

30. Name and address of person who completed cause of death (Item 23a) (Type, Print

only one

29b. Signature and title of

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29c. License number

29d. Date signed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 1 - For State Registrar State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ April 15^{pay} 2011 Elmer Charles Barnheart, Sr. 9:00am Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death 3925 Susanna Road Baltimore Randallstown Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth Sept. 30, 1922 Birthplace (State or Foreign Country) WV Funeral Months 1**X**□ M 2 □ F 216-12-7861 88 Yrs Director Usual Residence of Decedent 28a-f shov 10a. State 10b. County 10c. City, Town or Location Examiner must be notified at 10d. Inside City Limits Director MD Baltimore Randallstown 1 Yes 2 No 10g. Citizen of What Country? 10e. Street and Number ō 10f. Zip Code Funeral 21133 3925 Susanna Road permit. Page 1 and 2 should be filed within 72 hours after death v Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items any injury or other traumatic event, the Medical Examiner mu once. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status Was Decedent Ever in U.S. 14. Race - American Indian Armed Forces? Black, White, etc. þ 1 Never Married 2 X Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 X No Specify: WWII White 3 Widowed 4 Divorced Specify: Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) maritime Long Shoreman Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Harvey Barnheart Ruoff 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mrs. Joellyn E. Barnheart (Wife) 3925 Susanna Road, Randallstown, MD 21133 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State 1 🏋 Burial 2 □ Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify) Garrison Forest 4/21/2011 Owings Mills, MD 21. Signature of Funeral Service Licenses 22. Name and Address of Facility HAIGHT FUNERAL HOME & CHAPEL, PA Hayer PO Box 195 Sykesville, MD 21784 MO0766 23a. Part 1. Enter the disease, or complication that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on should be caused the death. Approximate Interval Between Tave Immediate Cause (Final Onset and Death Physician/ disease or condition resulting in death) Medical Examiner DVUNKY Sequentially list conditions Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury physician and s the burial-trans that initiated events resulting in death) Last Due to (or as a consequence of) Completed by Physician/Medical Division of Vital Records, P.O. Box 68760 for use as **Director:** After this certificate has been signed by the attending in by the funeral director, page 2 should be detached for use as IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
9 ☐ Unknown 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No 5 Other (specify) Month Day Year 1 Yes 2 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? • Hospital or Attending Physician: The law requires to 24 hours after death.
• Funeral Director: After this certificate has been sign. 1 \square Yes 2 \square No 3 \square Probably 4 \square Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an autopsy 1 ☐ Yes 2 ☐ No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home Hospital: ၉ 1 Tyes 5 Residence 6 Other (Specify) 1 Inpatient 2 I ER/Outpatient 3 I DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Duath Certificate: 28b. Time of 28c. Injury at work? 1 ☐ Yes 2 ☐ No 28d. Describe how injury occurred injury 1 Natural 5 Pending 2 Accident
3 Suicide
4 Homicide Investigation Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number determined City or Town, State) completed filled Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practions to the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) To the Vithin 2 29b. Signature and title of certifier 29d. Date signed Month. Day, Year, Wee

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31. Date filed (*Month, Day, Year*)

APR 18 2011

DHMH 17 Rev 7/2009

Registrar's Signature

Battimore MD 2/208

30 Name and address of person who completed cause of death (Item 23a) (Type, F

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Berlin Samue 1 11: 45A M 1105 April Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** SEASONS HOSPICE @ NORTHWEST HOSPITAL BALTIMORE RANDALLSTOWN If Under 1 Year If Under 24 Hrs. 8. Date of Birth Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) **Funeral** 1 X M 2 □ F 07/08/1920 **Director** 217-09-6154 90 NC Usual Residence of Decedent 28a-f show 10a. State 10b. County ral", or items 23a or 28a-f sho Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 X No MD BALTIMORE OWINGS MILLS 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 9812 ENDORA COURT 21117 USA 12. Was Decedent Ever in U.S.
Armed Forces?
1 ☑ Yes 2 ☐ No
If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, is marked other than "natural", or 1 Never Married 2 Married þ Maryland 21215-0036 1 ☐ Yes 2 X No Specify Specify. Completed 3 X Widowed 4 Divorced WHITE Year or Dates permit. Page 1 and 2 should be filed within 72 hour Department of Health and Mental Hygelen. Important if item 27 is marked other than "natur any injury or other traumatic event, the Medical! 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) 10College (1-4 or 5+) HAIR DRESSER BEAUTY SALON Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည LOUIS BERLIN ANNA ROSENZWEIG 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) JONAS MILLER/GRANDSON 1418 BALTIMORE STREET, #12224, HANOVER, PA 17331 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place 1 XBurial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) BNAI ISRAEL CONGR. 04/15/2011 BALTIMORE, MD 21. Signature of Funeral Service 22. Name and Address of Facility SOL LEVINSON & BROS., INC. 8900 REISTERSTOWN ROAD, PIKESVILLE, MD 21208 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Parkinsons Onset and Death Immediate Cause (Final End-Stage Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate Cause (Disease or linjury Due to (or as a consequence of) Exami The law requires that the death certificate be executed tran and that initiated events resulting in death) Last Due to (or as a consequence of) physician a the burial-Physician/Medical Box 68760 signed by the attending p IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) ___ in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day Year Pregnant at time of death g Unknown g Unknown P.O. Part II. <mark>Other significant condition</mark>s contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 🗹 No 3 ☐ Probably 4 ☐ Unknown Division of Vital Records, Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has e 2 yes 2 No 1 Yes the Hospital or Attending Physician: 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 4 Nursing Home 5 Residence 6 other (Specify) Hospital 1 Yes 2 1 No Other: ျ 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death Certificate: 28a. Date of injury (Month, Day, Year) 28c. Injury at 28b. Time of within 24 hours after death.

To the Funeral Director: After to completed filled in by the funera 28d. Describe how injury occurred 1 Natural 2 Accident 5 Pending 1 ☐ Yes 2 ☐ No Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier ☐ Verturing Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
☐ Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) US Ray apalmen. D D0057465 4/14/11 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Baltimore, MDZ1209 5-203 5- Rajapakse, M.B.

DHMH 17 Rev 7/2009

State Registrar 31. Date filed (Month, Day, Year)

32, Registrar's Signatur

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No... 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Bobrovskaya Month Year Dora 6', 12 PM API Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death SEASONS HOSPICE @ NORTHWEST HOSPITAL BALTIMORE RANDALLSTOWN 5. Social Security Number If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country)
 ROMANIA 7. Age (In vrs. last birthday) 8. Date of Birth **Funeral** 1 🗆 M 2 🗓 F Months Days Hours 0571771930 80 Yrs. Director 219-35-4006 Usual Residence of Decedent 28a-f shov 10b. County 10a. State the Maryland notified at 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 X No BALTIMORE BALTIMORE MD 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? items 23a or ner must be n with 1 Funeral 1500 BEDFORD AVENUE, 21208 USA 72 hours after death 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, Examiner Armed Forces?
1 ☐ Yes 2 🗓 No Black, White, etc. þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify. If Yes, Give Year or Dates "natural", Specify: Completed 3 X Widowed 4 Divorced WHITE Medical Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working I Hygiene. life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) 12 LABOR MANUFACTURING other Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) and Mental I ည SHULEM **GELFMAN** other traumatic JANE GELFMAN Department of Health and Important: If item 27 is n any injury or other traumonce. 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) LUBA GRAFF / DAUGHTER 56 GLYNDON GATE WAY, REISTERSTOWN, MD 21136 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other place 1 X Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) MEMORIAL PARK 04/15/2011 BETH EL RANDALLSTOWN, MD 21. Signature of Funeral Service Licensee 22. Name and Address of Facility SOL LEVINSON & BROS., INC. 8900 REISTERSTOWN ROAD, PIKESVILLE, MD 21208 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final cancer Physician/ Lung disease or condition Medical resulting in death) Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury that initiated events Due to (or as a consequence of) -transit requires that the death certificate be executed and Due to (or as a consequence of) resulting in death) Last attending physician a for use as the burial-Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
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4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) ___ in the past 12 months? Pregnant at time of death 1 Yes 2 No sate has been signed by the page 2 should be detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy certificate 1 ☐ Yes 2 ☐ No Yes 2 No 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital 4 Nursing Home 5 Residence 6 Other (Specify) 2 No မ 1 Yes 1 Inpatient 2 ER/Outpatient 3 DOA After this 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred the Hospital or Attending 1 Natural iniury 5 Pending 1 Yes 2 No death. 2 Accident
3 Suicide
4 Homicide neral Director: A Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined after City or Town, State) 24 hours Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check Gertifying Nurse Practioner: To the Sext of my knowledge. within 2 To the I 29b. Signature and title of certifier MSRUMPAMM NO 29c. License number 29d. Date signed (Month, Day, Year) D0057465 4/14/11

Registrar
DHMH 17 Rev 7/2009

2835

32. Legis Legis The ture

Baltimore, MD. 21209

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Ray 9 pakse, M.D.

31. Date filed (Month, Day 🖼

		_ State	Print in Black Indelible Ir ITEM#16a, perTH, g914, f Maryland / Department of Certificate of		Reg. N2. 0 1 1 1 2 3 2 5		
		Registrar 1 Decedent's Name (First, Middle, Last)	Λί		Date of Death 3. Time of Death		
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Examir	ner	The Johns Hopkins Hospital	Baltimor		NA		
uneral			7. Age (In yrs. last birthday) If Under 1 Yes Months Day	- I If I makes 0.4 Hrs. O Date of Di	trih 9. Birthplace (State or Foreign Country)		
ector >		Usual Residence of Decedent			10d. Inside City Limits		
s 1 and 2 should be filed within 72 hours after death with the Maryland of Health and Mental Hygiene. The marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at	tor	Total State Total Country					
or 28a e notif	Direc	10e. Street and Number	10f. Zip-Code		10g. Citizen of What Country?		
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<u></u> = 5		20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from 3		Date Date	20c. Location - City or Town, State		
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Important: any injury once.		Suf-Maki	Balto.	dress of Facility March F	TH 1101 5. WILLY HAVE		
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

AMEND TTEM#4b, perpHYS#10c, f, perFH, G914, 4/18/2011, ws
State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month APRIL Physician/ 02:35P M 2011 BERNICE HIRSCHHORN COHEN Medical n. City, Town, or Location of Death **Baltimore**OWINGS MILLIS 4a. Facility Name (if not institution, give street and number) 4c. County of Death Examiner BALTIMORE NORTH OAKS HEALTH CENTER Birthplace (State or Foreign Country) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 7, Age (In yrs. last birthday) 5. Social Security Number 6. Sex Funeral 1 □ M 2 🛭 F Months Days (Month, Day, Year) 04/25/1924 86 MD **Director** 219-18-2518 Usual Residence of Decedent or 28a-f show 10d. Inside City Limits 10a. State 10b. County 10c. City. Town or Location event, the Merical Examiner must be notified at Completed by Funeral Director Baltimore OWINGS MILLS 1 ☐ Yes 2 🔀 No BALTIMORE MD 10f. Zip Code 21208 21117 10g. Citizen of What Country? 10e. Street and Numbe 23a 725 MT. WILSON LANE, #420 or items 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 🎇 No 14. Race - American Indian 11. Marital Status Black, White, etc. 1 Never Married 2 Married 1 Yes Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: "natural", 3 X Widowed 4 Divorced WHITE Year or Dates 16a Decedent's Usual Occupation 15. Decedent's Education 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) other than Elementary/Seconday (0-12) College (1-4 or 5+) **PROFESSOR** EDUCATION Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) th and Mental h ပ HIRSCHHORN other traumatic JAMES 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) .. Page 1 and 2 sh tment of Health ar tant: If item 27 is ROBERT COHEN / SON 528 LINCOLN STREET, SAYRE, PA 18840 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State permit. Page 1 Department of Important: If it any injury or o cemetery, crematory or other place) X Burial 2 Cremation 3 Removal from State Other (Specify) BALTIMORE HEBREW CONG; 04/14/2011 BALTIMORE, MD 4 Donation 22. Name and Address of Facility SOL LEVINSON & BROS., INC. Signature of Funeral Service Licenses 8900 REISTERSTOWN ROAD, PIKESVILLE, 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between shock, or heart failure. List only one cause on each line. Onset and Death Immediate Cause (Final Physician/ witch disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Litter Underlying Cause (Disease or iinjury Examiner Due to (or as a consequence of) as the burial-transit that initiated events Due to (or as a consequence of): resulting in death) Last attending physician Physician/Medical To the Hospital or Attending Physician: The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months?

1 Yes 2 No Month Day Year Pregnant at time of death within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the a completed filled in by the funeral director, page 2 should be detached f g Unknown Part II, Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Be Completed by 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 1 🗌 Yes 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 1 ☐ Yes 2 ☐ No 26. Place of Death (Check only one) 25. Was case referred to medical examiner? Other: 2 No မ 1 \sum Yes 1 Inpatient 2 I ER/Outpatient 3 I DOA Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred Certificate: 28c. Injury at work?
1 \(\sup \) Yes 1 Natural 5 Pending 2 🗆 No Accident Investigation Suicide 6 Could not be Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 3 🗔 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) Enymora While mp DA768 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Kaymond Mille Averne Bar more 212 Simi 31. Date filed (Month, Day, Year) State racke Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. and #31 Per DVR G914 4/18/2011 JH
State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death COATES Year JEROME JAMES **Physician** 2351 M 2011 04 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** FREDERICE CALVERT MEMORIAL ItOSPITAL PRINCE CALNERI If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Days unk 1**X**M 2□ F Director 213-44-6016 17, 1943 Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County ed other than "natural", or items 23a or 28a-f show event, it is the lice Experiment aust by retiring at 1 ☐ Yes 2 📉 No Director MD Anne Arundel Lothian 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 20711 USA 931 Lower Pindell Road Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-if Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status 1 ∐Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 □Yes 2X No Specify: Specify: black 2 3 Widowed 4 Divorced UHW Completed unk 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) nt of Health and Mental Hygiene.

If item 27 Is marked other than or other traumatic event, It Item Item Elementary/Secondary (0-12) College (1-4or 5+) unk unk unk 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Aaron Coates ဥ 20732 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 3873 Gordon Stinnet Avenue Chesapeake Beach, John Rice/son 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition permit. Pages 1
Department of H
Important: If ite
any Injury or ot 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4□Donation 5ĬOther (Specify) in state Single Sirector State Anatomy Board 655 W. Baltimore Street Baltimore, MD 21201 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cau e (Final disease or con + n resulting in death) Respirator **Physician** /Medical Due to (r as a consequence of) Examiner . Cl Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner The law requires that the death certificate be executed cate has been signed by the attending physician and page 2 should be detached for use as the burial-trar Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day in the past 12 months? 5 ☐ Other (specify) 1 ☐ Yes 2 ☐ No 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 2 2 🔲 No 3 Probably 4 ☐ Unknown Hyperkension 1 Yes Completed certificate has been 24b. Were autopsy findings available prior to completion of cause of death?
1 □Yes 2XNo 24a. Was an autopsy performe 1 ☐ Yes 2 No or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certific completely filled in by the funeral director, it 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 27. Manner of Death 1 Natural 2 ☐ Accident Date of Injury 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred (Month, Day, Year) 5 Pending investigation 1 ☐ Yes 2 ☐ No 6 □Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide Hospital Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number 2 M() who completed cause of death (Item 23a) (Type, Print) rince frederict, MD 20678 32. Registrar's Signature 31. Date filed (Month, Day, Year) State Registrar

DHMH 17 Rev 1/2001

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Arvin Robert Durkin 04716/2011 3:30p Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** 2758 Wegworth Ln. Baltimore Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth Birthplace (State or Foreign Country) **Funeral** Sex 1 ☑ M 2 ☐ F 7. Age (In vrs. last birthday) 68 Hours 0272471943 217-40-1494 Director Usual Residence of Decedent 28a-f shov 10a. State 10b. County 10c. City. Town or Location ms 23a or 28a-f sho must be notified at 10d. Inside City Limits Director Baltimore MD 1XXYes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 2 should be filed within 72 now. 27 is marked other than "natural", or items 23? 27 is marked other than "natural", or items 23? 27 is event, the Me. ical Examiner must. 2758 Wegworth Ln. 21230 USA 11. Marital Status 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian. Armed Forces?

1 Yes 2 No Black White etc 1 Never Married 2 Married ģ Maryland 21215-0036 White If Yes, Give Year or Dates 1 ☐ Yes 2X No Specify: 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Maintenance Floor Care Technician Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 William Patrick Durkin Hermione Watson 1 and 2 should by Health and Meitem 27 is mark 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Patrick Durkin / Son 2647 Northshire Dr., Baltimore, MD 21230 permit. Page 1 and 2
Department of Health
Important: If item 27
any injury or other tr Baltimore, 20a. Method of Disposition
1 □ Burial 2 ☒ Cremation 3 □ Removal from State 20b. Place of Disposition (Name of 20c. Location - City or Town, State Arundel Crematory 04/19/2011 W. Odenton, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility
Bailey Funeral Home and Cremation Service, PA Miller M01452 4023 Annapolis Rd., Halethorpe, MD 2122 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause — each line.

Immediate Cause (Final Onset and Death Immediate Cause (Final Pnysician MRSA AND disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner CHRONIC 6BST CUCTIVE Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of): sician and burial-transit Exami Cause (Disease or iinjury that initiated events resulting in death) Last 104MU NOSUPPRESSED attending physician for use as the burial Physician/Medical Box 68760 IF FEMALE: 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ Live Birth 2 Fetal death in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day Year Pregnant at time of death the q | Unknown 9 Unknown Division of Vital Records, P.O. signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Completed peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an To the Hospital or Attending Physician: The law After this certificate has funeral director, page 2 % autopsy performe 1 Yes 2 No 1 Yes 2 No 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No ည 1 🗌 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred Certificate: iniury 1 Natural 5 Pendina death. 1 Yes 2 No 2 Accident
3 Suicide
4 Homicide Investigation within 24 hours after death

To the Funeral Director.
completed filled in by the 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) 🕊 certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) D0070917 3455 WILKENS AVENUE BAUTIMORE, MARYLAN 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) - SUITE LLID BETAVAND EEP 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month April 1 Bernard James Freeze 2011 98:34 AM Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Cerroll Hospital Conter Carroll Westminster 5. Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In vrs. last birthday) Birthplace (State or Foreign Country) Funeral 8. Date of Birth 1 **X**M 2 □ F Days $M_{ay}^{(Month)}1^{Day}$ Director 215-30-0477 MD Usual Residence of Decedent 28a-f show 10a. State Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 No MD Carroll Eldersburg 10e, Street and Number 10g. Citizen of What Country? items 23a Funeral 5734 Oklahoma Road 21784 USA 12. Was Decedent Ever in U.S. Armed Forces?

1 X Yes 2 No If Yes, Give 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black White etc. ģ 1 Never Married 2 XMarried Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify. "natural", White Completed 3 Widowed 4 Divorced Year or Dates Korea other traumatic event, the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) other than should be filed within 7 and Mental Hygiene.
7 is marked other than Elementary/Seconday (0-12) College (1-4 or 5+) 6 Management Analyst Social Security Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Bernard M. Freeze Anna M. Kohrs 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mrs. Lois M. Freeze 5734 Oklahoma Road Eldersburg, MD 21784 (Spouse) 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place, 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) injury or Lake View Mem.Park 4/20/2011 Sykesville, MD 22. Name and Address of Facility HAIGHT FUNERAL HOME & CHAPEL, PA 21. Signature of Funeral Service Licensee Duar Haight MOOTEY PO Box 195 Sykesville, MD 21784 23a. Part 1. Enter the disease, or complication that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Physician/ Right MCA Cerebouncular disease or condition Medical resulting in death) Examiner Lypoxic Respiratory Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events omplete Right ICA Due to (or as a consequence of) resulting in death) Last Physician/Medical phys the L IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) in the past 12 months? Day Year Pregnant at time of death Yes 2 ☐ No 9 Unknown g Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Dunbettes Type 2, Atrial Fibrillettur, Sleep aprica, Completed 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an Hypotrypo. diza To the Hospital or Attending Physician: The livitin 24 hours after death.

To the Funeral Director: After this certificate h performed Yes 2 X No 1 Tyes 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital Other: 1 ☐ Yes 2 💢 No ျှ 12 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 5 Pending 1 X Natural 2 Accident
3 Suicide
4 Homicide 1 ☐ Yes 2 ☐ No Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 1' Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier The deficial Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature nd title of certifie 29c, License numbe April 16,2011 D069086 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Chister Showing MD Carroll Huspital Center Westminster

DHMH 17 Rev 7/2009

State

Registrar

31. Date filed (Month, Day, Year)

8

Box 68760

P.0.

Records,

Division of Vital

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2 Date of Death 3. Time of Death Month Physician/ 2011 Bernard Gosnell Apri] 1: 15PM Medical 4a, Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Carroll Westminster Dove House Social Security Number 6 Sex 7. Age (In yrs. last birthdav) If Under 1 Year If Under 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** (Month, Day, Year) 1 □ XM 2 □ F Davs Hours Min. Months **Director** 215-20-7789 85 1926 Jan Usual Residence of Decedent or 28a-f shov notified at 10a. State 10b. County 72 hours after death with the Maryland 10c City Town or Location 10d. Inside City Limits Director MD Carrol1 Eldersburg 1 Yes 2 X No 10e, Street and Number 10f. Zip Code ò 10g. Citizen of What Country? "natural", or items 23a o Funeral 6201 North Walnut Avenue 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian Armed Forces?

1 X Yes 2 If Yes, Give
Year or Dates. Black. White, etc. 1 Never Married 2 X Married þ 2 No Maryland 21215-0036 WWII 1 ☐ Yes 2 🕅 No Specify: White Specify: 3 Widowed 4 Divorced Completed Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) than Ith and Mental Hygiene.
27 is marked other than r traumatic event, the M Elementary/Seconday (0-12) College (1-4 or 5+) filed within Superintendant Liberty Reservoir Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ٥ Burgess Aaron Gosnell Lillian Violet Briggs permit. Page 1 and 2 should be Department of Health and Ment Important: If item 27 is marke any injury or other traumatic once. 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mrs. Audrey A. Gosnell (Wife) 6201 North Walnut Avenue, Eldersburg, MD 21784 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place)
Lake View Mem. Park 1 X Burial 2 Cremation 3 Removal from State 4/19/2011 Sykesville, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility HAIGHT FUNERAL HOME & CHAPEL, PA PO Box 195 Sykesville, MD 21784 Hughes 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final h sician/ Molarteral disease or condition Medical resulting in death) Examiner Sequentially list conditions Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury that initiated events To the Hospital or Attending Physician: The law requires that the death certificate be executed the burial-transi Acute Reno Due to (or as a consequence of): resulting in death) Last physician Physician/Medical Division of Vital Records, P.O. Box 68760 attending pt I for use as the IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy
5 Other (specify) ____ in the past 12 months? Month Day ☐ Pregnant at time of death☐ Unknown Yes 2 No the detached 9 Unknown tate has been signed by page 2 should be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 🔀 No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy perform certificate 1 ☐ Yes 2 ☐ No Yes within 24 hours after death.

To the Funeral Director: After this certific completed filled in by the funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 - Nursing Home 5 - Residence 6 Other (Specify) 2 No 1 Tes မ 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred Natural 5 Pending 1 \square Yes 2 🗌 No Acciden Suicide Accident Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or injestic don, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a Certifier (Check 3 Certifying Nurse Practioner: To the b ath occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 1237949 0 h 23a) Type, Print) 30. Name and address of person who 32. Registrar's Si State

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death . Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death ^{Day}**2011** Year Physician/ Ap\math1 Raymond J. Gurney 8 12:10AM Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Rosedale 6416 Kenwood Avenue Baltimore 5. Social Security Number 6. Sex If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign 7. Age (In vrs. last hirthday) **Funeral** 1 XM 2 □ F Days Min. 10-28-1936 **Director** 74 212-34-3338 Usual Residence of Deceder 28a-f show 10a State 10b. County 10c. City, Town or Location with the Maryland aţ 10d. Inside City Limits Director notified MD Baltimore Rosedale 1X Yes 2 No P 10e Street and Numbe 10f. Zip Code 10g. Citizen of What Country? must be 23a Funeral 21237 6416 Kenwood Avenue USA items within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Medical Examiner Black, White, etc. 9 þ 1 Never Married 2 Married 1 Yes 2 No If Yes, Give Baltimore, Maryland 21215-0036 1 Yes 2 XNo Specify: Specify. 'natural", Completed 3 Widowed 4 Divorced White Year or Dates Decedent's Education 16a Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Il Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) traumatic event, the First Mariner Arena Maintenance Foreman Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) t. Page 1 and 2 should be file tment of Health and Mental I tant: If item 27 is marked o marked ည Albert Gurney Helen Kriss 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Virginia E. Gurney - Wife 6416 Kenwood Ave., Rosedale, MD 21237 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Department of Important: If it any injury or o ☐ Burial 2 X Cremation 3 ☐ Removal from State Atlantic Crematory 4-13-11 Glen Burnie, MD 4 Donation 5 Other (Specify) 22. Name and Address of Facility Bradley-Ashton Funeral Home Signature of Funeral Service Licenses 2134 Willow Spring Road, mplications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death 23a Part 1 Enter the disease or co. shock, or heart failure. List only one cause on each line Immediate Cause (Final Physician/ Cancer disease or condition Medical resulting in death) **Examiner** Sequentially list conditions Examine Due to (or as a consequence of). if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events resulting in death) Last burial-trans Due to (or as a consequence of): attending physician Physician/Medical Box 68760 as the l IF FEMALE: yes, outcome of pregnancy

Live Birth 2 Fetal death 3 Ectopic pregnancy

5 Other (specify) nse 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day Year signed by the a d be detached f 9 Unknown 9 Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Diabetes Division of Vital Records, 1 Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performed? Yes 2 No or Attending Physician: The this certificate 2 No 25. Was case referred to medical examiner?

1 Yes 2 No completed filled in by the funeral director, Be 26. Place of Death (Check only one) 2X No Hospital: ျှ 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 I ER/Outpatient 3 I DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: After work?
1 ☐ Yes 2 ☐ No 1 Natural 5 Pending Accident Investigation after death Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Hospital 24 hours a Funeral I Medical 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) the within To the 29b. Signature 0 124356

State Registrar 30. Name and address of person who completed c

Villiam Waterf

9103 Frankin Sq. Dr. Svite 2000.

use of death (Item 23a) (Type, Print)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygien State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2 Date of Death 3. Time of Death Physician/ 12^{ay} April 2011 Elvin Preston Green 6:30 P M Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Carroll Brinton Woods Health Care Center Sykesville 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth g. Birthplace (State or Foreign **Funeral** 1 X M 2 - F Hours Min Maryland Months Days Director 220-16-1588 87 Yrs Usual Residence of Decedent show 10a. State 10b. County filed within 72 hours after death with the Maryland ral", or items 23a or 28a-f shorexaminer must be notified at 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 K No New Windsor Maryland Carroll 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 3300 Sams Creek Rd. 21776 U.S.A.. 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Armed Forces?

1 Yes 2 No Black, White, etc. by 1 Never Married 2 Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 X No Specify: "natural", Specify: Completed 3 XWidowed 4 ☐ Divorced White the Medical 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) al Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) 8 dairy/transportation farmer/ truck driver Be permit. Page 1 and 2 should be filed Department of Health and Mental Hy Important: If item 27 is marked oth any injury or other traumatic eveni ones. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 Annie Baker William H. Green 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) James R. Green/son New Windsor, MD 21776 3300 Sams Creek Rd. 20a. Method of Disposition 20h Place of Disposition (Name of Date 20c. Location - City or Town, State cemetery, crematory or other place) 1 🔀 Burial 2 🗌 Cremation 3 🔲 Removal from State 4/15/2011 4 ☐ Donation 5 ☐ Other (Specify) Pipe Creek Cemetery : nr. Linwood, MD e of Fineral, Service Licen 22. Name and Address of Facility Hartzler Funeral Home Jarine (310 Church St. New Windsor, MD 21776 23a. Part 1. Enter the disease, or complication what caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate interval Between Onset and Death RECRIOSCIEROTIC Immediate Cause (Final Enysician/ CARDIOVASCULAR disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to for as a consequence on Hospital or Attending Physician: The law requires that the death certificate be executed and that initiated events Due to (or as a consequence of): resulting in death) Last attending physician a for use as the burial-Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) in the past 12 months? Pregnant at time of death 9 Unknown 9 Unknown signed by t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by MEW TUS 1 Yes 2 No 3 Probably 4 Unknown has been signed and be 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autonsy page death? After this certificate I 2 3 No Yes 1 Yes Be B 25. Was case referred to medical 26. Place of Death (Check only one) Hospital 1 ☐ Yes 2 ☐ No မ 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred iniury Natural 5 Pending 1 ☐ Yes 2 ☐ No Accident Investigation neral Director: / filled in by the f Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check Certifying Nurse Practioners of the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature ar d title of certifie 29c. License number 29d. Date Signed (Month, Day, Year) 20806 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) KETSTRSTON ND URMS PIUE USINOSS Center UD PR 1 8 201 32. Registrar's Signature State Registrar

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month Ina С. Hubard Medical 4a. Facility Name (if not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner If Under 1 Year If Under 24 Hrs. 8 Date of Birth 9. Birthplace (State or Foreign 7. Age (In vrs. last birthday) **Funeral** 1 🗆 M 2 🗓 F Months Days Hours 94 0972271916 Mary Tand **Director** 238-50-5268 Usual Residence of Decedent 28a-f shov 10b. County 10a. State 10c. City, Town or Location 10d, Inside City Limits notified at Director 1 ☐ Yes 2 🕅 No Maryland Baltimore Baltimore 9 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ral", or items 23a or Examiner must be Funeral U.S.A. 21093 313 Brightwood Club Drive death 11. Marital Status 12 Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Forces? Black, White, etc. þ 1 Never Married 2 Married Maryland 21215-0036 nan "natural", o Medical Exan If Yes, Give Year or Dates 1 ☐ Yes 2 X No Specify: Specify: White Completed 3 X Widowed 4 Divorced 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working filed within 72 tal Hygiene. life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) the Homemaker Own Home event, t Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) should be file h and Mental H **7 is marked o** permit. Page 1 and 2 should be fi Department of Health and Mental Important: If item 27 is marked any injury or other traumatic ev ပ္ Isabelle Miller Schamy1 Cochran 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Harbor Springs, MI 49740 John Bolling Hubard/ son 3759 Port Way Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other place) 1 Burial 2 Cremation 3 Removal from State Hilltop Service Corp. 04/19/2011 Towson, Maryland 4 Donation 5 Other (Specify) 22. Name and Address of Facility Towson, MD 21204 21. Signature of Funeral Service Licenses Ruck Towson Funeral Home, Inc. 1050 York Road 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one of the entertial control of the cardiac or respiratory arrest, shock, or heart failure. Interval Between Immediate Cause (Final Onset and Death Ph sician/ disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury Due to (or as a prinsequence f): Exami ardia physician and s the burial-trans that initiated events Due to (or as a consequence of) resulting in death) Last Medical P.O. Box 68760 attending ph IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death Physician/ 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) in the past 12 months?

1 Yes 2 No Month Pregnant at time of death g Unknown 9 Unknown , q signed t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by Division of Vital Records, or Attending Physician: The law requires 2 No 3 ☐ Probably 4 ☐ Unknown Completed 1 Yes page 2 should . Were autopsy findings available prior to completion of cause of 24a. Was an าสร autopsy perform death? certificate l 1 ☐ Yes 2 ☐ No 2 X No Yes Be 25. Was case referred to medical 26. Place of Death (Check only one) Hospital 2 X No Other: 1 Npatient 2 ER/Outpatient 3 DOA 잍 1 Yes 4 Nursing Home 5 Residence 6 Other (Specify) After this 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 Natural iniury work? 1 🗌 Yes 5 Pending 2 🗌 No ☐ Accident ☐ Suicide Investigation
6 Could not be Director: / 3 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide completed filled in by determined after City or Town, State) To the Hospital hours Funeral Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifier (Check 3 🗆 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. within 2 only one 29d. Date signed (Month, Day, Year) completed cause of death (Item 23a) (Type, Print) 30. Name and address of person who

State

Registrar

31. Date filed (Month) Day, Year)

8

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 1- State of Maryland / Department of Health and Mental Hygien 24a,25 per dr., g914.0418/2011dhb.
Registrar Registrar Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Date Month 3. Time of Death **Physician** :50 MCLIAM -201 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death **Examiner** Overlea Health& Rehab Center Baltimore N/A If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 01/16/1929 9. Birthplace (State or Foreign Country)
Maryland 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** Hours 1 3 M 2 F Months 1 4 1 Days 82 Director 214-26-3328 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 28a-f show if than "natural", or items 23a or 28a-f show the Murbon Evaning must be notified at 1 ☐Xes 2 ☐ No Director N/A Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? U.S.A. Funeral 6116 Belair Rd 21206 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11 Marital Status Black, White, etc. 1 Yes 2 ☐ If Yes, Give Year or Dates: 1 Never Married 2 Married 2 □ No Baltimore, Maryland 21215-0036 Specify: Black 1 □Yes 2 🛣 No Specify. à 3 ₩ Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry St. Matthews ould be filed within I Mental Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) 10th Grade Janitor Catholic Church is marked other 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Grant Hopp Mary Canty ည Department of Health and I Important: If item 27 is ma any Injury or other trauma 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Yvette Matthews(daughter 5903 Winner Ave., Baltimore, MD 21215) 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition Pages ' 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State on-site Crematory 04/08/11 4 ☐ Donation 5 ☐ Other (Specify) Baltimore, MD 21. Signature of Funeral Service Ccensee 22705866Mdrff.ofFaBrown Jr. Funeral Home PA Dunne 2140 N. Fulton Ave., Baltimore, 23a. Prrt1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Examiner tus Type - 2 Sequentially list conditions, if an leadin to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Physician: The law requires that the death certificate be executed sician and burial-tran attending physician Physician/Medical as the l Box If yes, outcome of pregnancy

1 Live birth 2 Fetal death

4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy for in the past 12 months? Month Day Year 5 Other (specify) 1 ☐Yes 2 ☐ No ned by the O. 9 T Unknown 9 Unknown σ. signed I be det Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 s autopsy performed? Yes 2 **X** No 2 No of Vital 1 ☐ Yes 1 ☐ Yes director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Medical Certification: To 27. Manner of Death
Natural
Accident 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Hospital or Attending 5 Pending death. 1 ☐Yes 2 ☐No investigation hours after death uneral Director: 6 ☐ Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 Homicide e Funeral I 29a. Certifier crtifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: 10 the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. completely (Check only one) within 2 To the I 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type Print) 5601-Loch aven 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death . Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Year PM Hummel 10:45 rances 2011 Medical 4a. Facility Name (if not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner BALTIMORE 7202 ROCKLAND HILLS DRIVE BALT IMORE 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 □ M 2 👿 F Months Days Hours Min 09/11/1915 95 **Director** 101-07-6633 NY Usual Residence of Decedent ıral", or items 23a or 28a-f shov I Examiner must be notified at Director 10a. State 10b. County 10d. Inside City Limits the Maryland 10c. City, Town or Location MD BALTIMORE **BALTIMORE** 1 🗆 Yes 2 🕅 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral Id be filed within 72 hours after death with Mental Hygiene. 7202 ROCKLAND HILLS DRIVE, 21209 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14 Bace - American Indian Armed Forces Black, White, etc. 1 Never Married 2 Married Completed by Yes 2X No Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 Yes 2XXNo Specify: WHITE "natural", 3 X Widowed 4 Divorced or other traumatic event, the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) marked other than Elementary/Seconday (0-12) College (1-4 or 5+) HECHT COMPANY SALESPERSON Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ဂ PHILIP BRODSKY **JENNIE** SEIDMAN 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <u>.v</u> permit. Page 1 and 2 sh Department of Health ar Important: If item 27 is any injury or other trau ILENE HUMMEL/DAUGHTER 7202 ROCKLAND HILLS DRIVE, #304 BALTIMORE, MD 21209 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State LIBERTY FORTERY OF CEM. 1 💢 Burial 2 🗆 Cremation 3 🗆 Removal from State 4 Donation 5 Other (Specify) 04/15/2011 RANDALLSTOWN, MD Signature of useral Service License 22. Name and Address of Facility SOL LEVINSON & BROS., INC. 8900 REISTERSTOWN ROAD, PIKESVILLE MD 21208 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between
Onset and Death shock, or heart failure. List only one cause on each line Immediate Cause (Final Physician Metastatic pancientic disease or condition resulting in death) Medical Due to (or as a consequence of Examiner Sequentially list conditions Examine r any, leading to immediate cause. Enter Underlying Cause (Disease or linjury Due to for as a consequence of Hospital or Attending Physician: The law equires that the death certificate be executed the attending physician and hed for use as the burial-trans that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Year Pregnant at time of death 5 Other (specify) Day Yes 2 No 9 Unknown g Unknown Isigned by the Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ amplimas 2 ☑ No 3 ☐ Probably 4 ☐ Unknown 1 Yes Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an is certificate has the director, page 2 s autopsy 2 [Yes B B 25. Was case referred to medica 26. Place of Death (Check only one) examiner? Other: 4 \(\to \) Nursing Home 5 \(\to \) Residence 6 \(\to \) Other (Specify) Hospital ျှ 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA After this 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred work? 1 Natural injury 5 Pending 2 🗌 No 2 Accident
3 Suicide
4 Homicide Investigation Director; / 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined ກ 24 hou₁ວ t**he Funeral Dire** ~~filled in City or Town, State) Medical 29a. Certifier 🚅 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated within 2 only one)

State Registrar 29b. Signature and title of certifier

Browner

31. Date filed (Month) Day Year

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Hastem

32 Registrar's Signatur

58893

Baltimore,

D

29d, Date signed (Month, Day, Year)

13

21224

ND

2011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Year Month DeSales L. Konen Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death earmi medical WILLO If Under 1 Year 8. Date of Birth (Month, Day, Jan 8 9. Birthplace (State or Foreign Country) Maryland Funeral 7. Age (In yrs. last birthday) If Under 24 Hrs. Days 1 □ M 2 😿 F Director 216-34-7152 1935 76 Usual Residence of Decedent "natural", or items 23a or 28a-f show edical Examiner must be notified at permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at 10b. County 10c. City, Town or Location 10d. Inside City Limits Director MD Worcester 1 Yes 2 No Berlin 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 43 Capetown Road 21811 USA 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 🖾 No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. ģ 1 Never Married 2 Married 1 Yes : Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: white Specify: Completed 3 Divorced 4 Divorced Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education unk 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) administrative assistant Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ္ John Edward Larkin Katherine Dougherty 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) John Konen/spouse 43 Capetown Road Berlin, MD 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State cemetery, crematory or other place) 4 X Donation 5 Qther (Specify) 21. Sign ture of Juneral Sovice Lice 1997 State and Address of Gard 655 W. Baltimore Street Director Baltimore, MD 21201 23a. Part Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ 5 My Brain Rul Part Fly disease or condition Day 5 Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, Examine Due to (or as a consequence of). if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events the attending physician and hed for use as the burial-transit or Attending Physician: The law requires that the death certificate be executed resulting in death) Last Due to (or as a consequence of): Completed by Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months? 1 ☐ Yes 2 ☐ No Month Dav Year 1 Yes 2 L 9 Unknown 9 Unknown signed by t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? End stage COID 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Swen CAD .- H, CABG 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an **Director:** After this certificate has a in by the funeral director, page 2: performed? Yes 2 No 25. Was case referred to medical Be 26. Place of Death (Check only one) 10 1 Tes 2 No Other: 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? Certificate: 28d. Describe how injury occurred Natural 5 Pending 1 Yes 2 No ☐ Accident Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) within 24 hours after or To the Funeral Direct completed filled in by 4 - Homicide Medical 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29d, Date signed (Month, Day, Year) DAMARS 4-12-2012 OKKOUS My 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 21804 10%

Registrar DHMH 17 Rev 7/2009

State

MILFORD

31. Date filed (Month, Day, Year)

12 6US

Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Norman M. Knight Year 8:20p 04/15/2011 Medical 4b. City, Town, or Location of Death Brooklyn Park 4a. Facility Name (if not institution, give street and number) Examiner 4c. County of Death Hammonds Lane Genesis Center Anne Arundel Social Security Number If Under 1 Year If Under 24 Hrs. Funeral 6. Sex 1 ☑ M 2 ☐ F 7. Age (In yrs. last birthday) 8. Date of Birth Birthplace (State or Foreign Country) Days 06/11/1937 212-34-6316 73 **Director** MD Usual Residence of Decedent "natural", or items 23a or 28a-f show edical Examiner must be notified at permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If teem 27 is anarked other than "natural", or items 23a or 28a-f sho any injury or other traumatic event, the Medical Examiner must be notified at any injury or other traumatic event, the Medical Examiner must be notified at 10b. County 10a. State 10c. City, Town or Location 10d. Inside City Limits Director MD Baltimore Halethorpe 1 Yes 2XXNo 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 2208 B Hammonds Ferry Rd. 21227 USA 12. Was Decedent Ever in U.S. Armed Forces?

12 Yes 2 No
1f Yes, Give 1957 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc 2 1 Never Married 2 Married Baltimore, Maryland 21215-0036 White 1 ☐ Yes 2XXNo Specify: 1957 Specify: Completed 3 Widowed 4 Divorced Year or Dates. 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Truck Driver Transportation 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) John N. Knight Evelyn Myers 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Nancy Knight / Wife 2208 B Hammonds Ferry Road, Halethorpe, MD 21227 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date W. Arundel Crematory 04/17/2011 1 Burial 2XXCremation 3 Removal from State Odenton, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Fyneral Service Licensee 22. Name and Address of Facility Bailey Funeral Home and Cremation Service, PA M01452 4023 Annapolis Rd., Halethorpe, MD 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Physician/ disease or condition resulting in death) 110 Medical Due to (or a /a onsequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Cause (Disease or iinjury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day Pregnant at time of death Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 X Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 2 X No 1 Yes 2 No Yes the Hospital or Attending Physician: 25. Was case referred to medical æ 26. Place of Death (Check only one) Other: 1 ☐ Yes 2 X No ည 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred 1 X Natural injury work? 1 ☐ Yes 2 ☐ No 5 Pending within 24 hours after death.

To the Funeral Director: A completed filled in by the fu Accident Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier 29c, License number 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) LERD LINTHICUM MD21090. W 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene for State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Physician/ KAHNTROFF 09374M TIGN Horil 2011 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death County of Death **Examiner** Hospita Randallstown Baltimore orthwest Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign Sex 1 X M 2 D F **Funeral** Months Days Hours Min 0370271950 218-54-3605 61 Yrs MD **Director** Usual Residence of Decedent 28a-f show 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits with the Maryland the Medical Examiner must be notified at Director 1 ☐ Yes 2 🄀 No BALTIMORE TIMONIUM MD 9 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? Funeral **23**a 535 LIMERICK CIRCLE 21093 USA items Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Was Deceue... Armed Forces? Yes 2 No 14. Race - American Indian, Black, White, etc. ō þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 Page 1 and 2 should be filed within 72 hours after 1 ☐ Yes 2 X No Specify: If Yes, Give Year or Dates 3 Divorced Specify: "natural" Completed WHITE 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) t of Health and Mental Hygiene.
If item 27 is marked other than
or other traumatic event, the Me Elementary/Seconday (0-12) College (1-4 or 5+) 5+ PHYSICIAN MEDICAL Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ KAHNTROFF STANLEY ANNETTE SNYDER 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) STEPHANIE KAHNTROFF / DAUGHTER 2910 ELLIOTT STREET, BALTIMORE, MD 21224 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other place) 1 🗌 Burial 2 ဳ Cremation 3 🗎 Removal from State ō Department of Important: If any injury or once. 4 ☐ Donation 5 ☐ Other (Specify) CARROLL CREMATION, INC 04/18/2011 HAMPSTEAD, MD 22. Name and Address of Facility SOL LEVINSON & BROS., INC. Signature of F 8900 REISTERSTOWN ROAD, PIKESVILLE, MD 21208 23a. Part 1 Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner Sequentially list conditions, Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or impury that initiated events Due to (or as a consequence of): the Hospital or Attending Physician: The law requires that the death certificate be executed the attending physician and hed for use as the burial-transit Due to (or as a consequence of): resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months? Month Day Year Pregnant at time of death 2 No been signed by the a should be detached 9 Unknown g Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Nnknown 24b. Were autopsy findings available prior to completion of cause of 24a. Was an After this certificate has page 2 autopsy death? Yes 2 No 1 Yes 2 No Be 25. Was case referred to medical examiner? funeral director, 26. Place of Death (Check only one) Hospital Other: 2 No 1 ☐ Inpatient 2 XER/Outpatient 3 ☐ DOA မ 1 🔲 Yes 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 28b. Time of 27. Manner of Death 28d. Describe how injury occurred Certificate: 28c. Injury at 1 Natural injury work?
1 Yes 5 Pending after death. Director: Aft 2 🗆 No Accident Investigation the Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide completed filled in by determined City or Town, State) 24 hours Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier D0062610

DHMH 17 Rev 7/2009

State Registrar Dandall Stown.

OUIT Road

Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print

raibi

Date filed (Month)

1010 10h

REPLA	Please Type or Print in I	Black Indelible Ink. Ensure A d / Department of Health and M	II Copies Are Legible lental Hygiene				
Life Co.	1- State Registrar	Certificate of Death	Reg. No. 2011	12339			
Physician/	1. Decedent's Name (First, Middle, Last) Vera Rose Kirchner		2. Date of Death Month APRIL 15, 2011	3. Time of Death			
Medical Examiner	4a. Facility Name (if not institution, give street and number)	4b. City, Town, or Location of Death	APRIL 15, 2011 4c. County of Dea	3:55P M			
Laminer	Saint Joseph Medical Cent	,					
Funeral Director	5. Social Security Number 220-14-6539 6. Sex 1 □ M 2 🗶 F 7. Age (In yrs. Ia 85	rst birthday) Yrs. If Under 1 Year If Under 24 Hrs. Months Days Hours Min.		rthplace (State or Foreign buntry) MD			
show lat		, Town or Location		10d. Inside City Limits			
ne Marylanc or 28a-f sho i notified at Director	MD Baltimore Timonium						
leath with the terms 23a or er must be n	10e. Street and Number 408 Rockfleet Road	10f. Zip Code 21093	10g. Citizen of What Co USA	ountry?			
items iner mu	11. Marital Status 12. Was Decedent Ever in U.S Armed Forces?	In It is a second of Hispanic Origin? (Specify Cuban, Mexican, Puerto Fundamental Programment of Hispanic Origin? (Specify Cuban, Mexican, Puerto Fundamental Programment of Hispanic Origin?)	cify Yes or No- Rican, etc.) 14. Race - Ame				
o36 s after call, or Examir	1 Never Married 2 Married 1 Yes 2 No If Yes, Give Year or Dates.	1 ☐ Yes 2 X No Specify:	Specify: Whi				
21215-003 rithin 72 hours at lene. r than "natural" the Medical Ex.	15. Decedent's Education (Specify only highest grade completed)	16a. Decedent's Usual Occupation (Give kind of work done during most of workin	16b. Kind of Business	Industry			
Vithin 7 vithin 7 iene.	Elementary/Seconday (0-12) College (1-4 or 5+)	life. DO NOT use retired) Homemaker	Own Home				
Maryland 21215-0036 2 should be filed within 72 hours after th and Mental Hygiene. 27 is marked other than "natural", o traumatic event, the Medical Exam To Be Completed by	17. Father's Name (First, Middle, Last) Vincent Svehla		(First, Middle, Maiden Surname) Machasky				
	19a. Informant's Name/Relationship (Type, Print) Nancy Yankolonis/Daughter	19b. Mailing Address (Street and Number or Rural 13 Glencoe Manor Court		' '			
Baltimore, semit. Page 1 and bepartment of Hea mportant: If item may injury or other pine.		lace of Disposition (Name of pemetery, crematory or other place)	ate 20c. Location - City or	Town, State			
Itimot it. Pagintment ritment injury of	4 Donation 5 Other (Specify)	eland Mem. Park 04/21	/2011 Baltimore,	MD			
Bal permi Depar Impo any ir	21. Signature of Funeral Service Licensee Paul D. Hagan per DVR	22. Name and Address of Facility Rucl	k Towson Funeral I wson, MD 21204	Home, Inc.			
Ph_sician/ Medical Examiner	23a. Part 1. Enter the disease, or complications that caused the death shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. HEMDERHAL Due to (or as a consequ	BIC STROKE	respiratory arrest,	Approximate Interval Between Onset and Death HUUR5			
	Sequentially list conditions, b.						
ecuted and Il-transit Examiner	Cause (Disease or linjury						
e be exect ysician an be burial-tr	that initiated events resulting in death) Last C. Due to (or as a consequence of): d.						
3876 ining ph	IF FEMALE: 23c. If yes, outcome of pregnar						
Division of Vital Records, P.O. Box 68760 To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit Medical Certificate: To Be Completed by Physician/Medical Exami		I death 3 Ectopic pregnancy	23d. Date of de Month	blivery Day Year			
B.O. s that the gned by be detacl	Part II. Other significant conditions contributing to death but not resu		23e. Did tobacco use contribute to				
rds,				2 No 3 Probably 4 Unknown			
of Vital Records, g Physician: The law requires er this certificate has been sig neral director, page 2 should b	ATRIAL FIBRILLATION		performed? death?	utopsy findings available completion of cause of s			
Vital Rec hysician: The la his certificate ha director, page 2	25. Was case referred to medical examiner?	26. Place of Death (Check		3 2 1110			
Physic this or ral dire	1 Yes 2 No No No No No No No No No No No No No						
on on on on on on on on on on on on on o	27. Manner of Death 1 X Natural 5 Pending 2 Accident Investigation 28a. Date of injury 28b. Time of injury 28b. Time of injury 28c. Injury at work? 1 Yes 2 No						
Division of rate of a steer death. al Director After the fine of in by the funeral of in Certificate:	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined 28e. Place of Injury - At honbuilding, etc. (Specify)	me, farm, street, factory, office	28f. Location (Street and Number or Ru City or Town, State)	ıral Route Number,			
he Hospita iin 24 hours he Funeral rpleted filled	29a. Certifier (Check only one) 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.						
To to with To to com	29b. Signature and title of certifier	29c. License number D52096	29d. Date signed (Mont	h, Dely, Year)			
	30. Name and address of person who completed cause of death (Item	, , , , , , , , , , , , , , , , , , , ,	JOON MODVI OND	21204			
State Registrar	31. Date filed (Month, Day, Year) 32. Pegistrar's Signat	A barle	AAMA POT ABLE TATALAN TO PER ELITARY	time rice (harrow 'se' F			

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Amend Items State of Maryland / Department of Health and Mental Hygiene 23a per dr., g914.04/18/2011dhb Certificate of Death State
Registrar Decedent's Name (First, Middle, Last) 2 Date of Death 3. Time of Death Day 2011 Physician/ March 31 Stanley F. Lukaszczyk 3:00 A M Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death St. ELizabeth's Nursing & Rehab N/A Baltimore Social Security Number Sex 14 M 2 D F 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign 8. Date of Birth **Funeral** Aug. 18, 1920 Pennsylvania Months Days Hours Min Director 175-14-7338 90 Yrs Usual Residence of Decedent Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director Maryland Baltimore Baltimore 1 Ves 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 1223 Oakland Terrace Road 21227 United states 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian, Armed Forces? 11 Yes 2 □ No Black, White, etc. Completed by 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 Yes 2 No Specify. White If Yes, Give Specify 3 Divorced Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4 or 5+) Elementary/Seconday (0-12) Federal Government Clerk Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Joseph Lukaszczyk Kunegunda Szuba 19a. Informant's Name/Relationship (Type, Print) Daughter-19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Stella C. Lukaszczyk/in-law 4256 Hermitage Dr., Ellicott City, Maryland 21042 20a. Method of Disposition Place of Disposition (Name of 20c. Location - City or Town, State Date cometery, crematory or other place)
[eadowridge Mem. Park Apr 2,2011 Elkridge, Maryland 1 Na Surial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) 22. Name and Address of Facility AMEROSE FUNERAL HOME, INC. f sceral Servic Lio eny 328 Sulphur Spring Rd., Arbutus, Maryland 21227 M 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) Medical (or as a consequence of) Examiner Hypertension Several years Sequentially list conditions, Dile to (or se a none equence ory cause. Enter Underlying Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or linjury attending physician and for use as the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical $\mathcal{Z}\mathcal{B}\mathcal{M}$ Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregna 5 ☐ Other (specify) Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Day Pregnant at time of death Month Year been signed by the should be detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 K No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has page 2 autopsy performed? Yes 2 No 2 🛛 No 1 Yes 25. Was case referred to medical examiner? the funeral director, Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 - Residence 6 - Other (Specify) 1 Tes 2 No ည 1 Inpatient 2 ER/Outpatient 3 DOA this (28a. Date of injury (Month, Day, Year) Manner of Death after death. 28b. Time of 28c. Injury at work? Certificate: 28d. Describe how injury occurred 1 Natural iniury 5 Pending 2 🗌 No Μ 1 Yes Accident Investigation 6 Suicide Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined 24 hours a Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated within 2 only one) Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of 2 29c. License number 29d. Date signed (Month, Day, Year) 23365 201 and address of person who confipleted cause of death (Item 23a) (Type, Print) d 05 Registrar's Signat State Registrar

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible State of Maryland / Department of Health and Mental Hygiene

		1- For State Registrar	•	te of Death	To Tribinian	,,	ı. No.	
Physic al Exam		1. Decedent's Name (First, Middle,Last) Kirk Alan Luczynski				2. Date of Death Month April 13, 20	Dav Year	3. Time of Death 2200 hrs
Black		4a. Facility Name (if not institution, give street and nut	mber)		or Location of Deat		4c. County of Death	
Funeral		University Hospital 5. Social Security Number 6. Sex	7. Age (In yrs. last birth	Balitmore day) If Under 1 Ye	ar If Under 24Hr	s 18 Date of Birth	(MM/DD/YYYY) 9. Bir	tholace (State or
Director		305-82-1723 1Xm 2 F	33	Yrs. Months Da			Foreig	
any		Usual Residence of Decedent 10a. State 10b. County	10c. City, Town o	r Location				10d. Inside City Limits
	Funeral Director	Maryland n/a		ltimore				1 X Yes 2 No
Marylaı 28a-f 1 d at on		10e. Street and Number		10f. Zip Code		10g	. Citizen of What Cou	ntry?
death with the Maryland or items 23a or 28a-f sho must be notified at once.		602 S. Hanover Street 11. Marital Status 12. Was Deck	edent Ever in U.S.		21230		U.S.A.	
leath w r items	uner	1 Never Married 2 K Married Armed Fo		 Was Decedent of H If Yes, specify Cuba 			White, etc.	ican Indian, Black,
s after o	by F	3 Widowed 4 Divorced If Yes, Give Year or Dates:		1 Yes 2 N			Specify: Whi	
72 hour "natu	eted	15. Decedent's Education (Specify only highest grad Elementary/Secondary (0-12) College (1-	dı.	ecedent's Usual Occupa uring most of working lif	ation (Give kind of e. DO NOT use ref	work done	6b. Kind of Business/	Industry
0036 within inner iene than	Completed	12 4	Sa	les Manage			Restaura	int
21215-0036 Muld be filed within 72 hou marked Hygiene. marked other than "mat e event, the Medical Exa	Be C	17. Father's Name (First, Middle, Last) Howard Milligan				e (First, Middle, Ma cia Milli	and the second second	
Z = 9	To I	19a. Informant's Name/Relationship (Type, Print) Patricia Milligan / Motl	19b.	Mailing Address (Stre	et and Number or	Rural Route Numb	er, City or Town, State	, Zip Code)
M 2 alth		20a. Method of Disposition	20b. Place of	Disposition (Name of co			20c. Location - City or	
Baltimore, permit. Pages I an Department of He Important: If ite injury or other training or other tr		1 Burial 2 X Cremation 3 Removal from 4 Donation 5 Other Specify:	III State	y or other place) Service Corp	4/1	19/2011	Towson, Ma	ryland
Baltimor permit. Pages I Department of I Important: If injury or other		21. Signature of Funeral Service Legacee		22. Name and Addres	ss of Facility Ruc	k Towson	Funeral H yland 212	lome, Inc.
Physician		23a. Part I. Enter the disease, or complications that ca	used the death. Do not	enter the mode of dying	KOACI TOV	VSON, Man or respiratory arres	y Land 212 t, shock, or heart	Approximate Interval
/Medical Examiner		failure. List only one cause on each line. Immediate Cause (Final disease a. Hanging						Between Onset and Death
		b	consequence of):		-			
	Iner	Sequentially list conditions,						
(Disease or injury that initiated C. Due to (or as a consequence of):								
760, cate be executed physician and the burial - transit	ical E	d. UNPENDED AMENDED	-					
760, cate be physicia	Medical	IF FEMALE: 23c. If yes, o	3c. If yes, outcome of pregnancy			23d. Date of delivery	,	
Box 687; death certific	23b. Was decedent pregnant in the past 12 months? 1 Live birth 2 Fetal death 3 Ectopic pregnancy Month Da 4 Pregnant at time of death 5 Other (Specify)						Day Year	
5.0. Boy that the death ned by the att detached for	2 250. Was decedent pregnant in the past 12 months? 1 Live birth 2 Fetal death 3 Ectopic pregnancy Month Day 1 Yes 2 No 9 Unknown 9 Unknown 9 Unknown 2 Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of the caus							
, P.O. res that th signed by be detach	ğ	Part II. Other significant conditions contributing to	litions contributing to death but not resulting in the underlying cause given in Part I.		given in Part I.	23e. Did tobacco use contribute to the cause of death 1 Yes 2 No 3 Probably 4 Unknown		
cords, aw require nas been si 2 should b	letec					24a. Was an		topsy findings available completion of cause of
						performed? death?		
Vital Rec ysician: The his certificate director, page	Be	25. Was case referred to medical examiner? 1 Ves 2 No Hospital: 1 V In	patient 2 ER/Out	26.Plac	e of Death (Check		esidence 6 Other	
1 Of Vi ling Physi After this funeral dir	. To	27. Manner of Death 28a. Date of (Month.	of Injury 28b. Tir	me of Injury 28c. Inju	ury at Work?	28d. Describe ho	w injury occurred	
	catio	2 Accident Investigation Apr 13, 2	011 2105 1	hrs '□	Yes 2 No	Subject hange		
Divisior pital or Attencours after death ceral Director: filled in by the	Certification:	Suicide Could not be	of Injury - At home, farm Townhouse / Rov		building, etc.	or Town, Star		ral Route Number, City re, MD
Division To the Hospital or Attent within 24 hours after death To the Funeral Director: completely filled in by the		29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.						
To th within To th	Medical	one) 2 Medical Examiner. On the basis of and manner states 29b. Signature and title of certifier		29c, Licen			29d. Date signed (Moi	
		in wi, no		O.C.	M.E.		April 14, 2011	
le		30. Name and address of person who completed cause Ling Li, MD Assistant Medical Exam		Street, Baltimore,	MD 21201			_
	tate		jistrar's Signature					
Regis	trar	MPR IO ZUII Chreen	B. parka	/				

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OCME

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiens Certificate of Death Reg. No 1. Decedent's Name (First, Middle, Last) 3. Time of Death 1:44a 2. Date of Death Physician/ APRIL 15^{ay} 201^yfar Herbert Lipman Α. Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death BALTIMORE **Examiner** 4b. City, Town, or Location of Death GREATER BALTIMORE MEDICAL CENTE TOWSON 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign 8. Date of Birth **Funeral** Days Hours Min. Mary land Director 218-22-4674 83 Usual Residence of Decedent ortant: If item 27 is marked other than "natural", or items 23a or 28a-f show injury or other traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City. Town or Location 10d. Inside City Limits Director Ma 1+imore 1 Yes 2 No Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral U.S.A. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11, Marital Status 14. Race - American Indian, Black White etc. 1 Never Married 2 Married ģ Maryland 21215-0036 1 ☐ Yes 2 No Specify: White Completed 3 Widowed 4 Divorced Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working and Mental Hygiene. is marked other than life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Watch Industry Repairman Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) permit. Page 1 and 2 should be the Department of Health and Mental Important: If item 27 is reary injury or other any injury or other page. ပ္ Schott Cecelia Lipman Jacob 19a. Informant's Name/Relationship (Type, Print)Daughter 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 211591159 Old Manchester Road Westminster, Maryland Inez Lipman-Richardson 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Dulaney and Tacher place, Memorial Gardens 1 💢 Burial 2 🗆 Cremation 3 🗆 Removal from State 4-19-2011 Timonium Maryland ☐ Donation 5 ☐ Other (Specify) Ruck Towson Funeral Home, 21. Signarun f Fundral ervice Lic 22. Name and Address of Facility 21204 Maryland 1050 York Road Towson, 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to for as a consequence of To the Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events Due to (or as a consequence of resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 1 Live Birth
4 Pregnant a
9 Unknown 3 Ectopic pregnancy in the past 12 months? Pregnant at time of death 5 Other (specify) n signed by the a 2 No 1 ☐ Yes ∠ ☐ 9 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Party 23e. Did tobacco use contribute to the cause of death? Completed by 2 No 3 Probably 4 Unknown 1 Tyes After this certificate has been significate has been significated and a should have a 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 2 🗆 No 1 Yes Be B 25. Was case referred to medical 26. Place of Death (Check only one) examiner? 1 X Yes Hospital: 2 No ၉ 1 Inpatient 2 ER/Outpatient 3 IDOA 5 Residence 6 Other (Specify) ASSISTED LIVE Monner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury 1 Natural 2 Accident 5 Pending within 24 hours after death.

To the Funeral Director: Aft 00 9,20113:151 work? W.sdizzy Investigation Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined building, etc. (Specify) Home 13.1+0 615 Chistaut Medical 29a. Certifier 1 Xcertifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check 29c. License number 29d, Date signed (Month, Day, Year) 00144 2011 井201 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 6565 N.Ch.-1. (Trenzer 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar

DHMH 17 Rev 7/2009

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygienes For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ April 2011 5:35 A M Jane B. Lidard Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City. Town, or Location of Death 4c. County of Death Presbyterian Home of Towson Towson Baltimore 5. Social Security Number 6. Sex If Under 1 Year If Under 24 Hrs. Hours Min. 8. Date of Birth 7. Age (In yrs. last birthday, 9. Birthplace (State or Foreign **Funeral** Days 1 🗆 M 2 🕱 F Months March 26 85 Mary Tand **Director** 220**-**14**-**3128 1926 Usual Residence of Decedent Department of Health and Mental Hygiene.
Important: Fage 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural" 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director Baltimore Parkville 1 Yes 2 X No Maryland 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Completed by Funeral U.S.A. 21234 1725 Weston Avenue 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces? Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2X No Specify: Specify: White If Yes Give 3 X Widowed 4 Divorced Year or Dates 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+ Telephone Company Toll Collections Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Margaret Theresa Baugh John Robinson Boland 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 8513 Drumwood Road Towson, Maryland Jane Daddezio / Daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State Dulaney Valley Mem Gardens 4/20/2011 4 ☐ Donation 5 ☐ Other (Specify) Timonium, MD . Signature of Funeral Service Licensed 22. Name and Address of Facility 1050 York Road MD 21204 Ruck Towson Funeral Home, Inc. Towson, 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line. Immediate Cause (Final Ph_{sician/} disease or condition resulting in death) one week Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of): Cause (Disease or iinjury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical To the Hospital or Attending Physician: The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?
1 ☐ Yes 2 ☑ No Month Year Pregnant at time of death Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ð Completed 1 ☐ Yes 2 X No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 ☐ Yes 2 🗷 No Yes 25. Was case referred to medical Certificate: To Be 26. Place of Death (Check only one) 1 Tes 2 Tho Other: 1 Inpatient 2 ER/Outpatient 3 DOA 49 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at eral Director: After filled in by the funera 28d. Describe how injury occurred 1 Natural 5 Pending work' Accident
Suicide 1 ☐ Yes 2 ☐ No Investigation Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) within 24 hours a

To the Funeral C

completed filled Medical 🕰 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 🔲 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 3 🗌 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 701 N. Charles St., Swite 4104 B. Ifmor, MD 21204 mo Kennet M. Greene, 6 32. Registrar's Signature State

DHMH 17 Rev 7/2009

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death **Physician** June Corrine Miller 12:00pm April 2011 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death Examiner Summerville Assisted Living Westminster Carroll Birthplace (State or Foreign Country) If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Months Days Hours 1 □ M 2 □ F Yrs. 213-20-0410 Director Sept 1, 1925 MD Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Event 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County 1 ☐ Yes 2 ☐ No Director MD Carrol1 Westminster 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 507 High Acre Drive Apt. 308 21157 USA Completed by Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 No If Yes, Give Year or Dates: 1 ☐ Never Married 2 Married 1 ☐ Yes 2 No Specify: Specify: White 3 Widowed 4 Divorced 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 Public School Secretary 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be William Conrad Gable Carrie Smith ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Mr. Robert Miller (Executor) 320 Kingston Circle, Sykesville, MD 21784 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State Lorraine Park Cemetery 4/18/2011 4 ☐ Donation 5 ☐ Other (Specify) Baltimore, MD 22. Name and Address of Facility HAIGHT FUNERAL HOME & CHAPEL, PA 21. Signature of Funeral Service Licensee PO Box 195 Sykesville, MD 21784 L. Haight - MOD764 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause or each line.

Immediate Cause (Final disease or condition resulting in death)

a. Approximate Interval Between Onset and Death **Physician** disease or condition resulting in death) /Medical Due to (or as a consequen brownsular Dinease Examiner Sequentially list conditions, any leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Physician/Medical Examiner Box 68760€ Due to (or as a consequence of): IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
9 ☐ Unknown 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy Month 5 Other (specify) 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performe certificate 1 ☐ Yes 2 No 2 □No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA Medical Certification: To

Hospital or Attending Physician: The law requires that the death certificate be executed P.O. Division of Vital Records, completely filled in by the funeral director, after death. To the Hospital within 24 hours a To the Funeral I

Registrar

27. Manner of Death
1 Natural
2 Accident

3 🗌 Suicide

29a. Certifier

4 Homicide

29b. Signature and title of certifier

5 Pending investigation

6 ☐ Could not be

28b. Time of

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28c. Injury at Work?

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

1 ☐ Yes

2 🗆 No

28f. Location (Street and Number or Rural Route Number, City or Town, State)

28d. Describe how injury occurred

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 8 Westminst

001 31. Date filed (Month, Day, Year) 32. Registrar's Signature

18 2011

28a. Date of Injury (Month, Day, Year)

and manner stated.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Abril Patricia Katherine Matsko 13. 20^Y1 9:05am M Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City. Town, or Location of Death 4c. County of Death Baltimore Gilchrist Hospice Towson 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Country) MD 1 □ M 2 🗓 F 68 Hours Jan . Bay, Yer 943 Director 217-40-9469 Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once. 10d. Inside City Limits 10a. State 10b. County 10c. City. Town or Location Director MD Carrol1 Woodbine 1 Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21797 USA 7404 Old Washington Road Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian Armed Forces?

1 Yes 2 No
If Yes, Give Black, White, etc. 1 Never Married 2 Married Completed by Baltimore, Maryland 21215-0036 1 Yes No Specify: 3 ★ Widowed 4 □ Divorced Specify: White Year or Dates 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Election Board Director of Election Board Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) ပ Julianna Goetz Stephen Seif 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 9506 Meadow Ridge Lane, Laytonsville, MD 20882 Mr. Martin J. Matsko, Jr. (Son) 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) cemetery, crematory or other place)
Lake View Mem. Park 4/19/2011 Sykesville, MD 22. Name and Address of Facility HAIGHT FUNERAL HOME & CHAPEL, PA 21. Signature of Funeral Service License ian (PO Box 195 Sykesville, MD 21784 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line. Immediate Cause (Final Physician/ disease or condition resulting in death) 皿 B Medical Due to as a consequence of) Examiner Sequentially list conditions Examiner Due to for earl generalizings of thany leading to immedicause. Enter Underlying Cause (Disease or iinjury the Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No Pregnant 5 Other (specify) Month Day Year Pregnant at time of death signed by the 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ò 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🔀 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an After this certificate has autopsy performe 2 No 1 Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital Other: 1 Yes 2 No ျ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 NOther (Specify) 28a. Date of injury (Month, Day, Year) 7. Manner of Death Certificate: 28b. Time of 28c. Injury at 1X Natural 5 Pending 1 Tyes 2 No Accident
Suicide after death Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined within 24 hours a To the Funeral C Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one 29c. License number 29d. Date signed (Month, Day, Year)

Registrar

State

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30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Registrar's S

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ JACK ALLEN MCCARTY APRIL 2049 2:44 A. M Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death 58 WHIPS LANE BALTIMORE PERRY HALL 5. Social Security Number 8. Date of Birth (Month, Day, Year) 11/23/1927 If Under 1 Year I if Under 24 Hrs. 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign Funeral 1**X** M 2 □ F Days Hours Min 83 WEST VIRGINIA **Director** 236-30-7646 Usual Residence of Decedent 28a-f show 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits must be notified at Director 1 Tes 2 No PERRY HALL MD BALTIMORE ō 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? items 23a Funeral 58 WHIPS LANE 21236 USA within 72 hours after death 11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. 0 þ 1 Never Married 2 Married 1 ☐ Yes 2 ☐ No If Yes, Give Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐XNo Specify: "natural", Completed 3 Widowed 4 Divorced WHITE Year or Dates Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life, DO NOT use retired) permit. Page 1 and 2 should be filed within 72
Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "I any injury or other traumatic event, the Mexicone. than, Elementary/Seconday (0-12) College (1-4 or 5+) RESTAURANTEUR OWNER 12th GRADE Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ CHARLES IRA MCCARTY BESSIE JANE DIXON 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) MARGARET P. MCCARTY/WIFE 58 WHIPS LANE BALTIMORE, MD 20a. Method of Disposition
1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other place)
METRO CREMATORY, INC. 4/16/2011 CATONSVILLE, MD 4 Donation 5 Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility THE JOHNSON FUNERAL HOME. P.A. MOO217 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on Immediate Cause (Final Physician/ Pa disease or condition resulting in death) pan Medical Examiner Sequentially list conditions. Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury Due to (or as a consequence of) Hospital or Attending Physician: The law requires that the death certificate be executed use as the burial-tran and that initiated events resulting in death) Last Due to (or as a consequence of): the attending physician Completed by Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No Month 5 Other (specify) Day Year Pregnant at time of death should be detached 9 Unknown this certificate has been signed by ng to death out not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Ne 1 🗌 Yes 2 1 No 3 Probably 4 Unknown 4b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 performed 1 Yes 2 No Be (25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital Other: ပု 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 5 Residence 6 □ Other (Specify, Certificate: 27. Manne of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred To the most after death.

To the Funeral Director: Aft atural 5 Pending work 2 Accident Investigation
6 Could not be 1 Yes 2 No Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examines: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) Signature and title 29c. License number d address of person who completed cause of death (Item 23a) (Type, Print) · RKG MID. REDRIC

DHMH 17 Rev 7/2009

Registrar

31. Date filed (Month, Day, Year)

32. Degistrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygien For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death O4Month Physician/ 12 2011 7:45 PM ELMER MANEY Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Arundel Anne Pasadena Birwood Court Birthplace (State or Foreign Country) If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth **Funeral** Hours 1 ▼M 2 □ F 73 NC 171 28 7928 **Director** Usual Residence of Decedent "natural", or items 23a or 28a-f show edical Examiner must be notified at 10d. Inside City Limits permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f shor any injury or other traumatic event, the Medical Examiner must be notified at 10b. County 10c. City, Town or Location 10a. State Director 1 🗆 Yes 2 🔀 No Pasadena MD Anne Arundel 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number Funeral Birwood Court 21122 U.S.A. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces Black, White, etc. 1 Never Married 2 Married Completed by 1 Yes If Yes, Give Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify. Specify: White 3 Widowed 4 Divorced Year or Dates 16a. Decedent's Usual Occupation 15. Decedent's Education 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Painter/Drywall Finisher Self Employed Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) ൧ Sadie Jane Moss Eddie B. Maney 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Birwood Ct. Pasadena, Carla Ardis - Niece 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2X Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Bayview Crematory 4/13/11 Baltimore, 22. Name and Address of Facility GJ Gonce Funeral 21. Signature of Juneral e Licensee Home, PA ID 21122 169 Riviera Drive Pasadena, MD Tenter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest Interval Between shock, or heart failure. List only one cause on each line Onset and Death Immediate Cause (Final Comer Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions. Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of) Hospital or Attending Physician: The law requires that the death certificate be executed use as the burial-transit and that initiated events resulting in death) Last Due to (or as a consequence of) the attending physician Completed by Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy
5 Other (specify) in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day Year 4 Pregnant a Pregnant at time of death been signed by the a should be detached 1 ☐ Yes ∠ ☐ 9 ☐ Unknown ed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy funeral director, page 2 performed' 1 Yes 2 No Yes 2 X No this certificate 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: 4 \(\sum \) Nursing Home 5 \(\mathbb{X}\) Residence 6 \(\sum \) Other (Specify) Hospital: 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA မှ 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: After 1 🔀 Natural 5 Pending To the Hospital or Attendir within 24 hours after death.

To the Funeral Director: Af completed filled in by the fu 1 ☐ Yes 2 ☐ No Accident
Suicide Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 🔀 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier Dairbr 4-13-11 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Bark St 350 8 to. And ZIDD LIBERTO 31. Date filed (Month, Day, Year) State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygienes Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Physician/ rima Meister Year PM Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Levindale Geriatric Center + Hospita Baltimore N/A 5. Social Security Numbe If Under 1 Year If Under 24 Hrs 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign Funeral Min. Months Hours 04/14/1915 219-56-6192 95 Director **POLAND** Usual Residence of Decedent item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at. 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 X Yes 2 ☐ No MD N/A BALTIMORE 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 2434 W. BELVEDERE AVENUE 21215 USA death Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S 14. Race - American Indian Armed Forces?

1 Yes 2XXNo Black, White, etc. 1 Never Married 2 Married Completed by 72 hours after Baltimore, Maryland 21215-0036 1 Yes 2XX No Specify: If Yes. Give Specify: WHITE 3 ♥ Widowed 4 □ Divorced Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) 2 should be filed within 7 th and Mental Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) HOMEMAKER OWN HOME æ 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ UNKNOWN PAK SARAH 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1 and 2 s of Health item 27 6200 GIST AVENUE, BALTIMORE, MD 21215 DOVID MEISTER/ SON 20a. Method of Disposition 20b. Place of Disposition (Name of permit. Page 1 a Department of In Important: If ite any injury or ot 1 X Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) SMATA CEM 04/15/2011 ROSEDALE.

22. Name and Address of Facility SOL LEVINSON & BROS., Signature of Funeral Service Licensee 8900 REISTERSTOWN ROAD, PIKESVILLE, MD 21208 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate shock, or heart failure. List only one cause on each line Immediate Cause (Final Pnysician/ disease or condition resulting in death) Medical Due to (or is a consequence of) Examiner Sequentially list conditions cause. Enter Underlying Cause (Disease or iinjury Due to for as a nonsequence of that the death certificate be executed that initiated events Due to (or as a consequence of): resulting in death) Last burial-1 attending physician for use as the burial Physician/Medical Box 68760 IF FFMALE 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month 5 Other (specify) Year Pregnant at time of death 9 \ Unknown 9 Unknown Division of Vital Records, P.O. à signed to Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ the Hospital or Attending Physician: The law requires 2 No 3 ☐ Probably 4 ☐ Unknown Completed should ! 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was ar nas page 2 autopsy nerform certificate 1 ☐ Yes 2 ☐ No Yes 2 XN 25. Was case referred to medica Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify 2 No ည 1 Inpatient 2 ER/Outpatient 3 DOA within 24 hours after death.

To the Funeral Director: After thi
completed filled in by the funeral is 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No Accident Investigation 6 Could not be Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 X Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) bello Mouse CRNP 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) M. Eletta Mosse CRNP, 2434 W. Belvedere Ave, Baltimore MD 21215 31. Date filed (Month, Day, Year) State

DHMH 17 Rev 7/2009

Registrar

APR 18

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Physician/ Month WILLIAM RAY NITTERRIGHT, JR. 2:12 PM 2011 Medical 4c. County of Death 4a. Facility Name (if not institution, give street and number) City, Town, or Location of Death **Examiner** Anne Arundel Baltimore Washington Medica alon Burnie If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign 8. Date of Birth Social Security Number 6. Sex 1 M M 2 □ F 7. Age (In yrs. last birthday) **Funeral** Min. Count Maryland Days Sept 3, 1942 217-38-1934 69 Director Usual Residence of Decedent ral", or items 23a or 28a-f shov Examiner must be notified at 10d. Inside City Limits Page 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene. ant: If item 27 is marked other than "natural", or items 23a or 28a-f sho 10a. State 10b. County 10c. City, Town or Location Director Glen Burnie Anne Arundel Maryland 1 Yes 2 No 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Numbe 21061 Funeral 517 Munroe Circle USA 12. Was Decedent Ever in U.S. Armed Forces?
1 ☐ Yes 2 ※ No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 Yes 2 No Specify Specify: White 3 Widowed 4 Divorced Completed Year or Dates 27 is marked other than "natu traumatic event, the Medical 16a, Decedent's Usual Occupation 16b. Kind of Business Industry 15. Decedent's Education (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Seconday (0-12) Unknown College (1-4 or 5+) Super Fresh Warehouseman Unknown Be 17. Father's Name (First, Middle, Last 18. Mother's Name (First, Middle, Maiden Surname) ್ತ William Ray Nitterright, Sr. Flora Trower 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Sue W. Nitterright (Wife) 517 Munroe Circle, Glen Burnie, Maryland permit. Page 1 and 2 Department of Health Important: If item 27 any injury or other tr 20b. Place of Disposition (Name of cemetery, crematory or other place, 20c. Location - City or Town, State 20a. Method of Disposition 1 ₭ Burial 2 Cremation 3 Removal from State Meadowridge Memorial Park Apr 15, 2011 Elkridge, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility McCully-Folyniak Funeral Home, P.A. 21. Signature of Funeral ervice Licensee Kevin E Ecker 237 E. Patapsco Avenue, Baltimore, Maryland 21225-1856 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner TNINA Sequentially list conditions Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of) Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-transi that initiated events Due to (or as a consequence of) resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months? Month Day Year Pregnant at time of death Yes 2 ☐ No been signed by the should be detached 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown After this certificate has been funeral director, page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an performed 1 Yes 2 No Yes 2 No 25. Was case referred to medical examiner?
1 ☐ Yes 2 ☐ No Be 26. Place of Death (Check only one) Other: ၉ 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: Natural work? 5 Pending 1 Yes 2 No Accident Investigation
6 Could not be within 24 hours after death

To the Funeral Director:,
completed filled in by the □ Accide
 □ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Certifying lurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29d, Date signed (Month, Day, Year, 29b. Signature and title of certific who completed cause of death (Item 23a) (Type, Print) 32. Registrar's State Registrar

DHMH 17 Rev 7/2009

Nitherright, Wm

Please Type or Print in Black Indelible Ink, Ensure All Copies Are Legible.
AMEND ITEM#12perFH, 6914, 4/1872011, WS
State of Maryland / Department of Health and Mental Hygiene Reg. No. Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month **Physician** Sr. elvin ulliam /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Age (In y s. last birthday) and Dec Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Funeral Hours Min. 1 M 2 □ F Months 26 212512 Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County 28a-f show permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylal Department of Health and Mental Hygiene. Important: If Item 27 Is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at 1 Yes 2 □ No Baltimore Director MD 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 2/205 USA Washington St. 830 N. Funeral Race - American Indian Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 You If Yes, Give 11. Marital Status 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 No Specify þ Black 3 Widowed 4 □ Divorced Year or Dates: Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15 Decedent's Education $\mathcal{M}\mathcal{U}_{\mathcal{U}} \sim \Gamma \mathcal{U}_{\mathcal{U}}$ Baltimore, Maryland 21215-(Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) National Gypsum Inspector 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be ulliam 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Pulliam, Jr. afayette St. Batto., MO -Don Melvin 700 20b. Place of Disposition (Name of cemetery, crematory or other 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 □ Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify) -21-2011 Owings Mills, MD Garrison Forest Vet. Cent 22. Name and Address of Facility March F/H 1151 E. North Ave. 21. Signature of Fun Service Licensee Balto, MD 21202 Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner ng physician and as the burial-transit Due to (or as a consequence of) Records, P.O. Box 68760, attending physician Physician/Medical IF FEMALE led by the attendin detached for use 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy Month Dav Year in the past 12 months? 5 ☐ Other (specify) 1 ☐ Yes 2 ☐ No 9□Unknown 9 ☐ Unknown ate has been signed by page 2 should be detact 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ģ 1 ☐ Yes 21 No 3 ☐ Probably 4 ☐ Unknown 10000 Completed 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy performed? 2□ No 10 2 | No Yes Division or Vital To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifica completely filled in by the funeral director, p 25. Was core referred to medical examiner?

1 Yes 2 No Be (26. Place of Death Check onl one Other: 4 Nursing Home 5 Residence Hospital: 6- Other (Specify) Chronic 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 27. Manuar of Death 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred 28b. Time of 28c. Injury at Work? Injury 1 / Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 4 ☐ Homicide 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 32. Registrar's Signature 31. Date filed (Month, Day, State Registrar DHMH 17 Rev 1/2001

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registra Certificate of Death 1. Decedent's Name (First, Middle, Last) 2 Date of Death 3. Time of Death Physician/ BERLDENE S. PICKENS APRIL 201^{Year} 5:45 A, M Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City. Town, or Location of Death 4c. County of Death 9505 KINGSCROFT TERRACE PERRY HALL BALTIMORE UNIT C 5. Social Security Number Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign 8. Date of Birth **Funeral** Days 1 X M 2 D F Months Hours 218-28-4155 M943 94 933 Director KANSAS Usual Residence of Decedent 28a-f show 10a. State 10b. County with the Maryland Examiner must be notified at 10c. City. Town or Location 10d. Inside City Limits Director 1 Yes 2 X No BALTIMRE PERRY HALL 10e. Street and Number ò 10f. Zip Code 10g. Citizen of What Country? Funeral 23a 9505 KINGSCROFT TERRACE UNIT Q 21128 USA "natural", or items filed within 72 hours after death 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specity Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian Armed Forces?

1 Yes 2 No Black, White, etc 1 Never Married 2 Married þ Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 X No Specify WHITE Specify: 3 Widowed 4 Divorced Completed al Hygiene. d other than "natura event, the Medical E 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry
BALTIMORE CO. PUBLIC (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) **EDUCATOR SCHOOLS** YEARS Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) and Mental Fis marked of ٥ permit. Page 1 and 2 should be. Department of Health and Menta Important: If item 27 is marked JOHN LINDALHL PICKENS VERA DOANE 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code 1128 19a. Informant's Name/Relationship (Type, Print) JOAN M. PICKENS/WIFE 9505 KINGSCROFT TERRACE UNIT Q PERRY HALL, MD 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place 20c. Location - City or Town, State 1 ★ Burial 2 Cremation 3 Removal from State injury or GARDENS OF FAITH CEM. 4/20/2011 PARKVILLE, MD 4 Donation 5 Other (Specify) 21. Signature of Funeral Service Vicenses 22. Name and Address of Facility THE JOHNSON FUNERAL HOME, MO1139 any i 8521 LOCH RAVEN BLVD. TOWSON. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line Immediate Cause (Final Physician, disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No Month Day Year Pregnant at time of death 5 Other (specify) Yes been signed by the should be detached a Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 2 /J NO 1 Yes 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of 24a. Was an page 2 After this certificate has autopsy performe 1 Yes 2 No 1 🗌 Yes 25. Was case referred to medical funeral director, Be 26. Place of Death (Check only one) examiner? Other: 1 🗌 Yes 2 No 2 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 Residence 6 ☐ Other (Specify) Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28d. Describe how injury occurred 28c. Injury at 5 Pending Natural 1 Yes 2 No Accident Investigation after death Director: / Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide determined 24 hours a Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. completed Additional Examiner on the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Plactioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check within 2 29b. Signature and title of certifier 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DHMH 17 Rev 7/2009

State Registr<u>ar</u> 31. Date filed (Month)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician Cackson awrence 1229 AM 04 401 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Baltimore Medical Baltimore Mercy If Under 1 Year II Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 8. Date of Birth (Month, Day, Days Hours Months 216-18-4027 Yrs. Director 23 Marylano Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits ir then "natural", or Items 23a or 28e-f ehow The Mudical Examinar must be notified at 1 ☐ Yes 2 🔀 No Director Marvland Baltimore Lutherville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? U.S.A. Alston Road 21093 by Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. permit. Pages 1 end 2 should be filed within 72 hours after Department of Health and Mental Hygiene. Important: If Item 27 is marked other then "natural", or Ite eny Injury or other traumatic event, the Mudical Examina 1 Never Married 2 Married 1 NYes 2 No If Yes, Give Year or Dates: WWII Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🗓 No Specify: 3 Widowed 4 Divorced White 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 4 Tele-Communications Electric Engineer 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Joseph Rackson Helen Rodowsky 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 17 Alston Road, Lutherville MD 21093 Regina Rackson/wife 20b. Place of Disposition (Name of cemetery, crematory or other place 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Hilltop Service Corp. 04/18/2011 Towson, Maryland 21. Signature of Funeral Service Licensee 22. Name and Address of Facility 1050 York Rd. towson MD 21204 OWSON Tunera 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or he in failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician ementa disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any leading to immediate cause. Enter Underlying Cause (Disease or injury that inflated events resulting in death) Last Examiner Due to (or as a consequence of) use as the burial-transit To the Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760. Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy ò in the past 12 months? Month Day Year 4☐Pregnant at time of death 5 Other (specify) 1 Yes 2 No 9 Unknown 9 Unknown Pag II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ Completed 1 ☐ Yes 2 ☐ No 3 ☐ Probably 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 1 ☐ Yes 1 ☐ Yes 2 ☐ No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one Hospital: Other: 4 Nursing Home 1 Yes 2 No 1 Inpatient 2 ER/Outpatient Certification: To 3□ DOA 5 Residence 6 Other (Specify) After thi 27. Manner of Death 1 Natural Date of Injury (Month, Day 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation Injury within 24 hours after death.

To the Funerel Director: Af death. 1 ☐ Yes 2 Accident 281. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, lactory, office building, etc. (Specify) 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) NPI 1679898134 MD who completed cause of death (Item 23a) (Type, Print) Baltimore, Paul 05 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 23a,24a,25 per me/verb.,2914 04/15/2011dhb
Registrar

Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ March 26 Day ZOMAYA SHLEIMON SOLOMON 2011a 4:42 Ам Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Frederick Memorial Hospital Frederick Frederick Social Security Number **Funeral** 7. Age (In yrs. last birthday, 8. Date of Birth 9. Birthplace (State or Foreign 1 X M 2 D F Months Days Hours Min. (Month Day Year) 25 **Director** 332-30-2107 85 Syria Usual Residence of Decedent or 28a-f show 10a, State 10b. County other traumatic event, the Medical Examiner must be notified at 10c. City, Town or Location Director 10d. Inside City Limits 1 Yes 2 No MD Carrol1 Westminster 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? items 23a Funeral 4089 Della Drive 21157 USA death v . Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14. Race - American Indian, Armed Forces If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. "natural", or þ 1 Never Married 2 Married Yes 2 X No Maryland 21215-0036 filed within 72 hours after 1 Yes 2 X No Specify If Yes, Give Completed 3 Divorced 4 Divorced Specify: White Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed, Department of Health and Mental Hygiene. Important: If item 27 is marked other than "any injury or other traumant. Elementary/Seconday (0-12) College (1-4 or 5+)
5+ Linguist U.S. Government Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Shlimon Zomaya Nimo Nisan 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Nancy J. Solomon/Wife Page 1 and 2 4089 Della Dr., Westminster, MD 21157 timore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State cemetery, crematory or other place) 4 Donation 5 Other (Specify) Elmwood Cemetery 4/2/2011 River Grove, IL 21. Signature of Fu Baj eral Service License ²Burrier Queen Funeral Home & Crematory, P.A. 1212 W. Old Liberty Rd., Winfield, MD 21784 23a. Pag 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, art failure. List only one cause on each line. ock, or he Interval Between Onset and Death diate Cause (Final Physician/ Entracerebra Hemanihap rippietr Medical Due to (or as Examiner Stroke Sequentially list conditions, if any, leading to immediate Examine Due to (or as a consequence of) or Attending Physician: The law requires that the death certificate be executed Cause (Disease or iinjury use as the burial-tran and APPROVED BYTHES that initiated events resulting in death) Last Due to (or as a consequence of): attending physician Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death
9 Unknown 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) in the past 12 months? Day Year signed by the a Yes 2 No Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? à Completed 1 Yes 2 No 3 Probably 4 Unknown Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 s has autopsy performed? Yes 2 X No 1 Yes 2 No 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospita 1 X Yes Certificate: To Other: 1 Nation 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending injury work?
1 Yes 2 No Accident Investigation Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number 4 Homicide City or Town, State Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check 3 29b. Signature and title of certifier MDO69963 m.0. 30. Name and address of person who ted cause of death (Item 23a) (Type, Print) 400 W, 7th street frederick, M

State

SANDHYA 31. Date filed (Month, Day, Year) APAUT

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. For State Registrar State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Walter April Schurman Angus 16, 2011 2:42pm Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death 6 Martz Road Sykesville Carroll 5. Social Security Number 8. Date of Birth Sept 24, 1923 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs 9. Birthplace (State or Foreign **Funeral** Days 1**X** M 2 □ F Months Hours 87 Nova Scotia Director 015-30-4677 Yrs Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f shown injury or other traumatic event, the Medical Examiner must be notified at once. 10a. State 10b. County 10c. City, Town or Location Director 10d. Inside City Limits MD Carroll Sykesville 1 Yes 2 XNo 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 6 Martz Road 21784 USA 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or Nolf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian. Black, White, etc. þ 1 Never Married 2 X Married 1 ☐ Yes 2 ☐XNo If Yes, Give Year or Dates. Baltimore, Maryland 21215-0036 1 ☐ Yes 2 XNo Specify. Completed 3 Divorced White 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Tool & Dye Machinist Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ၉ Alec Schurman Maude Rhindress 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mrs. Ruby S. Schurman (Wife) 6 Martz Road, Sykesville, MD 21784 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Burial 2 XCremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) All County Cremation 4-18-11 Sykesville, MD 21. Signature of Funeral Service Licenses 22. Name and Address of Facility HAIGHT FUNERAL HOME & CHAPEL, PA tta 400764 Sykesville. MD 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ wose disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner nerthision Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Examiner attending physician and for use as the burial-transit Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of) resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months? igned by the atte be detached for Day Year Pregnant at time of death Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 2 No 3 Probably 4 Unknown page 2 should Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy certificate Yes 1 Yes the funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 1 Tes Other: မ 1 Inpatient 2 ER/Outpatient 3 IDOA After this 27. Manner of Dath 28a. Date of injury (Month, Day, Year) Certificate: Natural 28b. Time of 28c. Injury at 28d. Describe how injury occurred work? 5 Pending 2 No ☐ Accident Investigation Could not be 24 hours after deat Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) completed filled in by 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated within 2. 3 🗆 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one 29b. Signature and title of certifier 30. Name and address of person who dompleted cause of death (Item 23a) (Type, Print)

Registrar

DHMH 17 Rev 7/2009

State

31. Date filed (A

32. Registrar's Sig

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2 Date of Death Physician/ AMonth VERA M. STOKES 9:30A Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City. Town, or Location of Death 4c. County of Death Baltimore Washington Medical Glen Burnie Anne Arundel Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) 8. Date of Birth **Funeral** 1 🗆 M 2 🔀 F Months Days Hours Min. 01 14 Pay, Director 212 26 7797 80 931 Usual Residence of Decedent show 3a or 28a-f shov t be notified at 10a. State 10b. County 10c. City, Town or Location Director 10d. Inside City Limits 1 Tes 2 No MD Anne Arundel Pasadena 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? 23a Funeral rral", or items 23a I Examiner must b 114 Montrose Rd. 21122 U.S.A. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces?
1 ☐ Yes 2 🔀 No Black, White, etc. Completed by 1 Never Married 2 Married Page 1 and 2 should be filed within 72 hours after 1 ☐ Yes 2 X No Specify: If Yes, Give Specify: 3 Divorced 4 Divorced Year or Dates White permit. Page 1 and 2 should be filed within 72 hours Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natur any injury or other traumatic event, the Medical. 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Baltimore, Maryland 21 6 <u>Homemaker</u> Own Home Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Howard P. Jenkins Catherine Elizabeth Middleton 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) David A. Stokes - Husband 114 Montrose Rd. Pasadena. MD 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date 1 🗶 Burial 2 □ Cremation 3 □ Removal from State cemetery, crematory or other place) 4 ☐ Donation 5 ☐ Other (Specify) MDVeterans Cem 4/22/11 Crownsville, MD Signature of Funer - epice Licensee 22. Name and Address of Facility GJ Gonce Funeral Home 169 Riviera Drive Pasadena, 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Immediate Cause (Final Onset and Death Ph_{sician/} disease or condition resulting in death) TONINEST Medical Examiner 210 Sequentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury the Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): been signed by the attending physician should be detached for use as the burial by Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: yes, outcome of pregnancy
Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 🗔 Ectopic pregnancy in the past 12 months?

1 Yes 2 No Pregnant at time of death 5 Other (specify) Month Day Year 9 Illnknown Qther significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? No 3 ☐ Probably 4 ☐ Unknown Completed 1 🗌 Yes has been 24a. Was an 24b. Were autopsy findings available prior to completion of cause of autopsy perform death? After this certificate 2 🗌 No 1 🗌 Yes Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 \sum Nursing Home 5 \sum Residence 6 \sum Other (Specify) ျ 1 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury 28b. Time of 28c. Manner of Death Certificate: 28c. Injury at 28d. Describe how injury occurred (Month, Day, Year) 1 Natural 5 Pending work? 2 🗀 No Accident Investigation within 24 hours after death

To the Funeral Director: of completed filled in by the Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 29b. Signature and title of certifier 1041 30. Name and add ess of person who completed cause of death (Item 23a) (Type, State

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Registrar

18

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygien Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Physician/ Month 1437 Juanita CY Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Bultimore, M.D NONE Medical Certe 9. Birthplace (State or Foreign Country) If Under 1 Year If Under 24 Hrs. 8. Date of Birth Social Security Number (In vrs. last birthday) Yrs. **Funeral** 212-72-8327 1 🗆 M 2 🕱 F Director or items 23a or 28a-f show permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d, Inside City Limits Director M.D1 Yes 2 No Baltimore 10f. Zip Code 10g. Citizen of What Country? Completed by Funeral 21229 Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Race - American Indian, 11. Marital Status Armed Forces Black, White, etc. 1 Never Married 2 Married 1 Yes Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: 3 →Widowed 4 □ Divorced Year or Dates 16a. Decedent's Usual Occupation 15. Decedent's Education 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) College (1-4 or 5+) /Secoliday (0-12) Be ည State, Zip Code) 21244 19b. Mailing Address 20b. Place of Disposition (Name of cerhetery crematory or other place) 20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) Signature of Funeral S rvice License a 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or hear tenure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Ner- ischenic h sician/ disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner ad Stan 20 4 years Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Examiner been signed by the attending physician and should be detached for use as the burial-transit the Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No Month Year Pregnant at time of death 5 Other (specify) 4 ☐ Pregnant : 9 ☐ Unknown 1 Yes 2 g 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an this certificate has autopsy page 2 performed Yes 2 1 ☐ Yes 2 ☐ No 25. Was case referred to medical examiner? funeral director, 26. Place of Death (Check only one) Be Hospital 2 **N**o 1 Inpatient 2 FR/Outpatient 3 I DOA မ 1 🗌 Yes 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at work? 1 ☐ Yes Certificate: 28d. Describe how injury occurred within 24 hours after death. To the Funeral Director: After injury Natural 5 Pending 2 🗌 No 2 Accident
3 Suicide
4 Homicide Investigation completed filled in by the 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check only one) 29b. Signature and titl 29c. License number 14740 2011 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 21202 James Ling Place Paul - 30 I 54. 31. Date filed (Month, Day, Year) APR 18 2011 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Mont 23:50 AM Esterman STIN e Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Anne Arundel Annapolis Anne Arundel Medical Center Social Security Numbe 214–40–1230 If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign . Age (In vrs. last birthday) **Funeral** Min. 1 □ M 2 🏝 F Hours Feb 18. 1944 Months Maryland 67 Director Usual Residence of Decedent 28a-f show 10b. County 10d. Inside City Limits "natural", or items 23a or 28a-f shovedical Examiner must be notified at 10a. State 10c. City, Town or Location Director Stevensville Maryland Oueen Annes 1 Yes 2 X No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 512 Zaidee Lane 21666 USA within 72 hours after death 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, 11. Marital Status Armed Forces Black, White, etc þ 1 Never Married 2 X Married 1 Yes If Yes, Give 2 X No Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify: White 3 Divorced Completed Year or Dates traumatic event, the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15 Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Page 1 and 2 should be filed within 72 nent of Health and Mental Hygiene. ant: If item 27 is marked other than " MTA Elementary/Seconday (0-12) Toll Collection Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Joseph Sammers ပ Josephine Kay Schmidt 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Donald R. Testerman (Son) 518 Buckingham Drive, Stevensville, Maryland 21666 permit. Page 1 and 2 Department of Healt Important: If item 2 any injury or other 1 other 20b. Place of Disposition (Name of cemetery, crematory or other place)
Cedar Hill Cemetery 20a, Method of Disposition 20c. Location - City or Town, State 1 X Burial 2 Cremation 3 Removal from State 4/16/2011 Baltimore, Maryland 4 Donation 5 Other (Specify) 22. Name and Address of Facility McCully—Polyniak Funeral Home, P.A. 237 E. Patapsco Avenue, Baltimore, Maryland 21225—1856 21. Signature of Funeral ervice Licensee Kevin E Fcker 237 E. Patapsco Avenue, Baltimore, Maryland 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final Fnysician disease or condition resulting in death) 48 CV Medical Due to (or as a consequency of): Examiner Sequentially list conditions. Examine if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of) To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the Innertal director, page 2 should be detached for use as the burial-transit Cause (Disease or liniury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 4 Pregnant : 9 Unknown Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 ≠ 9 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 1 Yes 2 Ko Yes 2 No 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Other: 2 No ည 1 Appatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: 1 Natural 5 Pending 1 Yes 2 No 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) Medical 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier The section of the se 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Suk 210 Annyola 2003 medice 31. Date filed (Month, Day, Year) State Registrar 8 201

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death ^{Day} 2<u>011</u> Physician/ April Cyril Paul Weamer 13 9:10 AMM Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Anne Arundel Medical Center Annapolis Anne Arundel Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign 7. Age (In vrs. last birthday) **Funeral** Hours July 28, Year 1922 1 🕅 M 2 🗆 F Pentysylvania 88 **Director** 182-14-8044 Usual Residence of Decedent or 28a-f show 10a. State 10c. City, Town or Location 10d. Inside City Limits within 72 hours after death with the Maryland the Medical Examiner must be notified at Director 1 Yes 2X No Anne Arundel Crownsville 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? "natural", or items 23a Funeral 1454 Fairlfield Loop Road 21032 USA 12. Was Decedent Ever in U.S. Armed Forces?

1

Yes 2 □ No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian Black. White, etc. 1 Never Married 2 ☐ Married þ Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: white Specify: Completed 3 Widowed 4 Divorced 42-43 Year or Dates. 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) permit. Page 1 and 2 should be filed within 72 Department of Health and Mental Hygiene. Important: If item 27 is marked other than any injury or other traumatic event, the Me College (1-4 or 5+) Elementary/Seconday (0-12) electronics computer operator Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Margaret Rosella Prough Cyril Edward Weamer 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Jay Weamer/brother 1052 Omar Drive Crownsville, MD 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other place ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 X Donation 5 Other (Specify) Signature of Euneral S 3 NavendAffattoffy:"Board 655 W. Baltimore Street Mixector 21201 Baltimore, MD 23a. Pard 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between shock of heart failure. List only one cause on each line.

Immediate Cause (Final Onsel and Death Intarction Myocardial Pnysician/ days disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Univerlying Examine Due to (or as a consequence of) Hospital or Attending Physician: The law requires that the death certificate be executed 24 hours after death.

Funeral Director: After this certificate has been signed by the attending above and the control of the c Cause (Disease or iinjury that initiated events resulting in death) Last the burial-transi Due to (or as a consequence of): attending physician Physician/Medical Division of Vital Records, P.O. Box 68760 as IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death
4 Pregnant at time of death
9 Unknown use 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ the funeral director, page 2 should be detached for in the past 12 months? Month Year Day 2 No 9 Unknown been signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 Mo 3 ☐ Probably 4 ☐ Unknown Completed Winary Tract Intection 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an After this certificate has autopsy 2 **X** No 1 Yes 2 No 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital: 1 Yes 2 No Other: ျှ 1 M Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 Natural injury work?
1 ☐ Yes 2 ☐ No 5 Pending s after death. Accident Investigation 3 ☐ Suicide 4 ☐ Homicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, completed filled in by determined City or Town, State) Medical 🏿 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29c. License number 29b. Signature and title of ce 29d. Date signed (Month, Day, Year) D46052 4/13/11

State Registrar Year,

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Poul wing an apolis Fub

32. Registrar's Sigrature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day Willis 45 **Physician** PM ebecca Delle 27 02 2011 /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Baltimore Medi If Under 1 Year | If Under 24 Hrs. 8 Date of Birth (Month, Day) Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) **Funeral** 1 M 2 K 0 Yrs. 27 Mary Director Usual Residence of Decedent 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location 28a-f show permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, I've "Marical Examiner in ust be notified at 1 Wes 2 □ No Director BaltIMORE ND 10g. Citizen of What Country? 10e. Street and Number STREEPER STREET 21334 Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Bace - American Indian 11. Marital Status 1 Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify. þ Black 3 Widowed 4 Divorced Completed 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) INFANT INFANT 0 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be LINKNO WN 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Sharita Busto, MD 21224 413 -MOTHE! 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Methed of Disposition Date 1 Burial 2 □ Cremation 3 Removal from State 4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility unera IN PRODUZIANA HOME 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) 0-days Physician ~M~ /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-tran Due to (or as a consequence of) Box 68760? Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death
4 Pregnant at time of death
9 Unknown 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy Month Year 5 Other (specify) P.O. signed by the NIA 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Records, þ 1 Yes 2 No 3 Probably 4 Unknown this certificate has been s al director, page 2 should Completed 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy performed? 1 ☐ Yes 2 2 No 2 X No Division of Vital 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2. No Inpatient 2 ER/Outpatient 3 DOA 2 funeral 28a. Date of Injury (Μοητή, Day, Year) 28b. Time of Injury 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred After Medical Certification: 1 Natural 5 Pending investigation within 24 hours after death.

To the Funeral Director: A completely filled in by the fu 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 ☐ Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier and manner stated. To the 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifie 2011 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) ai 32. Registrar's Signature 31. Date filed (Month, Day, Year) State

DHMH 17 Rev 1/2001

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) April 1⁶, 20T1 Physician/ 10:35 Zephir Marion J. Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (if not institution, give street and number) Examiner Baltimore <u>Catonsville</u> Charlestown Retirement Community 9. Birthplace (State or Foreign 8. Date of Birth If Under 1 Year If Under 24 Hrs. 7. Age (In vrs. last birthday) ^{Year}19<u>27</u> **Funeral** 1 M 2 F (Month, Day, Hours Mary Land Months Days 216-20-0676 83 Director Usual Residence of Decedent or 28a-f show notified at 10d. Inside City Limits 10c. City, Town or Location 10a. State within 72 hours after death with the Maryland Director 1 Yes 2 X No Pasadena Anne Arundel Marvland 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number ms 23a or must be r ò Funeral II.S.A. 1209 Rock Hill Road 21122 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. "natural", or item ledical Examiner n 11. Marital Status Black White etc. Armed Forces þ 1 Never Married 2 Married Yes 2 X No 3altimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: If Yes, Give White 3 Widowed 4 Divorced Completed Year or Dates the Medical 16a. Decedent's Usual Occupation 16b. Kind of Business Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) permit. Page 1 and 2 should be filed within 72 Department of Health and Mental Hygiene. Important: If item 27 is marked other than '9 any injury or other traumatic event, the Me any injury or other traumatic event, the Me once. Elementary/Seconday (0-12) College (1-4 or 5+) Own Home Homemaker Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) 2 Kozlowski Bertha Reddish Harry 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) MD_21136 Sagamore Forest Lane Reisterstown David W. Zephir (Son) 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 X Burial 2 Cremation 3 Removal from State 04/14/2011 Brooklyn Park, Maryland 4 Donation 5 Other (Specify) Holy Cross Cemetery 22. Name and Address of Facility McCully-Polyniak Funeral Home, P.A. 3204 Mountain Road Pasadena, Maryland 21. Signature of Funeral Service Licenses 21122 23a, Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate shock, or heart failure. List only one cause on each line Carda Variale artariox levotic Immediate Cause (Final Physician xacer bottom disease or condition Medical resulting in death) Due to (or as a consequence of) **Examiner** Sequentially list conditions if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of) To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director, After this certificate has been signed by the financial of the funeral Director. Cause (Disease or linjury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ Dav in the past 12 months?

1 Yes 2 No
9 Unknown 4 ☐ Pregnant 9 ☐ Unknown Pregnant at time of death Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? à 1 Tes 2 No 3 Probably 4 Tunknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 1 ☐ Yes 2 ☐ No 25. Was case referred to predica 26. Place of Death (Check only one) Be examiner? Other: 1 Tes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 2 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: work? 1- Natural 5 Pending 1 ☐ Yes 2 ☐ No 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifi 00035297 ۷ 16 30. Name and address of berson who completed cause of death (Item 23a) (Types, Print) hora LN. Catonsville Mn 21226 14 der Michae 31. Date filed (Month, Day, Year) Registrar's Signatur State APR 8 Registrar

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 2. Date of Death 3. Time of Death Decedent's Name (First, Middle, Last) April Physician/ 20^{par} ΑМ 5:52 Brintzenhofe Vernard Medical 4b. City, Town, or Location of Death 4a. Facility Name (if not institution, give street and number) 4c. County of Death Examiner Washington 2 Chartridge Drive Hagerstown If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Pay, Mar • 12, 9 Birthplace (State or Foreign . Age (In yrs. last birthday) Social Security Number **Funeral** Days Hours Ohio 1 X M 2 □ F Mar. 297-12-7256 86 Director Usual Residence of Decedent show 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location with the Maryland notified at Director 1 Yes 2 No 28a-f MD Hagerstown Washington 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number or than "natural", or items 23a or the Medical Examiner must be Funeral 2 Chartridge Drive 21742 U.S.A. death Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. 11. Marital Status Armed Forces?

1 X Yes 2 No
If Yes, Give Black, White, etc. permit. Page 1 and 2 should be filed within 72 hours after to Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or any injury or other traumatic event, the Medical Examinonce. þ 1 Never Married 2 X Married Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: Specify: 3 Widowed 4 Divorced White Completed Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during 16b. Kind of Business Industry Decedent's Education (Give kind of work done of the control of the contr (Specify only highest grade completed) during most of working Elementary/Seconday (0-12) College (1-4 or 5+) Facilities Engineer US Government Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 Homer Brintzenhofe Christine Gallugher 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) A. Lucille Brintzenhofe/Wife Chartridge Dr., Hagerstown, MD 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 X Burial 2 Cremation 3 Removal from State 4/16/2011 4 ☐ Donation 5 ☐ Other (Specify) Rest Haven Cemetery Hagerstown, MD 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Rest Haven Funeral Chapel 1601 Pennsylvania Ave., Hagerstown, MD ns that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, 23a. Part 1. Enter the disease, or complications that caused shock, or heart failure. List only one cause on each line. Interval Between set and Death, Immediate Cause (Final Ph_sician/ disease or condition Medical resulting in death) Due to (or as a conseque Sequentially list conditions, Examine Due to lor as a consequence of cause. Enter Underlying Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or linjury attending physician and for use as the burial-trans that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Month Dav 5 Other (specify) Pregnant at time of death signed by the at d be detached for 9 I Inknown g 🗌 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by Probably 4 🗆 Unknown 1 🗌 Yes 2 🗌 No 3 Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 s has autopsy perform 1 🗌 Yes 2 🔲 No this certificate director, 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Other: 4 Nursing Home 5 X Residence 6 Other (Specify) 1 🗌 Yes ၉ 1 Inpatient 2 ER/Outpatient 3 DOA funeral Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: work? 1 ☐ Yes 2 ☐ No 1 Natural 5 Pending Investigation n 24 hours after death e Funeral Director: A eleted filled in by the f Accident Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

State Registrar

completed

within 2

(Check

only one

29b. Signature and title of certific

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Reg

DHMH 17 Rev 7/2009

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29d. Date signed (Month, Day, Year)

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 31^{Pay} 201 1^{ear} ROBERT ARCHIE BARNES MARCH 12:45 A M 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death CHERRY LANE NURSING CENTER LAUREL PRINCE GEORGES . Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign 8. Date of Birth Months Days Min. Hours 1 X M 2 D F SEPT. 7, 1932 MARYLAND 216-74-0077 78 Usual Residence of Decedent 10h. County 10c. City, Town or Location 10d. Inside City Limits PRINCE GEORGES LAUREL 1X Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 33 ORCHARD TOWNE COURT, #105 20707 UNITED STATES 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Forces?
1 ☐ Yes 2 🗶 No Black, White, etc. 1X Never Married 2 Married 1 ☐ Yes 2 X No Specify: 3 Divorced If Yes, Give Specify: BLACK Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) UNEMPLOYED NONE 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) CHARLES H. BARNES SR. JANIE ELIZABETH FORD BARNES 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 33 ORCHARD TOWNE COURT, #105, LAUREL, MD ELIZABETH EDELEN/NIECE 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) ST. METTHEWS OH CEMETERY APRIL 6, 2011 NEWTOWN, MARYLAND 21. Signature of Funerat Service Represent 5 100583 Name and Address of Facility
3439 LIVINGSION ROAD, INDIAN HEAD, MD 20640 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final PNEUMONIA) Approximate Interval Betwe 4º6 WEEKS disease or condition resulting in death) Due to (or as a consequence of): SEPTICEMIA 4-6 WEEKS Due to (or as a consequence of): 2 WEEKS consequence of): s, outcome of pregnancy Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Pregnant at time of death Day 5 Other (specify) Month Year Yes 2 No 9 Unknown Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Yes 2X No 3 ☐ Probably 4 ☐ Unknown DM, HYPERTENSION 24b. Were autopsy findings available prior to completion of cause of 24a. Was an 1 Yes 2 No

Physician/ Medical **Examiner**

Baltimore, Maryland 21215-0036

Box 68760

P.O.

Records,

Division of Vital

After this

filled in by

ie Hospital or Attending Pl n 24 hours after death. ie Funeral Director: After th

Physician/

Medical

10a. State

MD

Examiner

Funeral

Director

28a-f shov

must be notified at

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permit. Page Department of Important: If any injury or once.

Funeral Director

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Completed

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Sequentially list conditions, if any, leading to immediate

Cause. Enter Underlying Cause (Disease or iinjury that initiated events	AZOTE
resulting in death) Last	Due to (or as a d
IF FEMALE:	23c. If yes, outcome of

ATRIAL FIBRILLATION

25. Was case referred to medical	Т

			perfo	rmad? 2 No	death?
	26. Place	of Death (Check onl	y one)		
2 ER/Outpatient 3	DOA Other:	Nursing Home	5 Resid	lence 6	Other (Specify)

death? 1 ☐ Yes	2 🛣 No	

27. Manner of Death
1 X Natural
2 Accident

1 X Natural	5 Pending
2 Accident	Investigat
3 Suicide	6 Could not
4 Homicide	determine

L inpatient 2 L	LIVOUL
te of injury o <i>nth</i> , <i>D</i> ay, Year)	28b. Tii inj

28a. Date of injury (Month, Day, Year)	28b. Time of injury	М	28c. Injury at work? 1 Yes	2 🗆 No
28e. Place of Injury - At he building, etc. (Specify		t, facto	ory, office	

	28d. Describe how injury occurred	
0		

29a.	Certifie
	(Check
	only or

Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated

Эb.	Signatu	e and t	itle of	certifier	
		R	22-	-	-

PHYSICIAN

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ı	D	00	5	72	16

29d. Date signed (Month, Day, Year) MARCH 31, 2011

28f. Location (Street and Number or Rural Route Number, City or Town, State)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

determined

MICHAEL BAAKO, 3450 FORT MEADE ROAD, #209, LAUREL, MARYLAND 20724 31. Date filed (Month, Day, Year)

State Registrar

32. Registrar's Signature APR 0 5 2011

28a. Da

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			For State			State of M	arylan	•					lental Hy	giene		1 1	101	200
			Registrar	(F) . A4: 1 !!	141			Cer	tifica	te of D	Death			Reg. No.	U		16	363
п	Physicia	an/	1. Decedent's Nam										2. Date of De Month	ath Day		Year	3. Time o	М
	Medic Examir		Dougla: 4a. Facility Name (ii						4b Cit	y, Town, or	1 ocation	of Death	April	140	20	11 y of Death	17:40	<u>p</u> "
	Exami		1306 0	ld Dru	mme	rboy La	ne		Ft.			gtor				•	eorge	
	Funeral		5. Social Security N		6. Sex			ast birthday)		er 1 Year		er 24 Hrs.	8. Date of Birl (Month, Da	th		9. Birtl	hplace (State	
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	show dat	tor	10a. State	10b. County			10c. Cit	y, Town or Lo	cation	-							10d. Inside 0	City Limits
	Mary 28a-f otifie	Director	Va.	Fairf	ax		Fa:	lls Cl	nurc	ch							1 🗶 Ye	s 2 🗆 No
	th the 3a or t be n	alD	10e. Street and Nur							ip Code				10g. Citi	zen of	What Cou	untry?	
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9	er dec or ite miner	by Fi	1 Never Mari	ried 2 🗌 Mari		Armed Forces?		It	f Yes, sp	ecify Cubar	n, Mexica	an, Puerto	Rican, etc.)			ce - Amer ck, White	ican Indian, , etc. Bla	ak
03	ırs aft ural", IExal	ted t	3 🗆 Widowed	4 🗖 Divorced		If Yes, Give Year or Dates.		1	☐ Yes	2 🗷 No	Specif	y:			Specify	<i>/</i> :	ьта	.CK
21215-0036	within 72 hours after death with the Manyland glehe. er than "natural", or items 23a or 28a-f sho er than Medical Examiner must be notified at	Completed	(Spe	15. Deceder ecify only highe				16a. Deced (Give i	kind of w	ork done d		st of worki	ng	16b. Kii	nd of E	Business I	ndustry	
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Maryland	permit. Page 1 and 2 should be filed within 72 hours after death with the Manyland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.		19a. Informant's Na		ір (Туре	e, Print)		1	-				Route Numbe				,	
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Baltimore,	permit. F Departm Importal any injul		21. Signature of Fu			0 1		_ 22	. Name a	and Addres	s of Faci	lity Phil	I. PBell					ete-
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				rt failure. List o	complic nly one	cations that caused cause on each line	the deatl	h. Do not ente	r the mo	de of dying	g, such a	s cardiac c	r respiratory ar	rest,			Approxima Interval Be	tween
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	outed nd ransit	Examiner	that initiated event	S	c.											_		
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Division of Vital Records,	al or A s after I Direct d in b		4 Homicide	determ	ined	building, etc			et, lacto	ry, office			City or Tow		Numb	er or nure	ar noute ivurri	ber,
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	the H thin 24 the F mplete	Me	only one) 3	☐ Certifying	Nurse	r: On the basis of ex Practioner: To the	pest of my	/ knowledge, d	leath occ	urred at the	e time, da	te and plac	e, and due to the	e cause(s)	and m	anner as s	stated.	armer stated.
	5 ≥ 6 8		29b. Signature and	True	(1/2	M	2 0		lc. License		777			-		Day, Year)	
J			30. Name and addr	ess of parent	yho con	pleted cause of de	eath (Item	23a) (Tivne P	rint)	10103	7069	12			<i>r</i> -	04	-201	1
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2364 State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month 5;28 PM 20,201 march LAVERNE BRASWELL Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death DOCTORS HOSPITAL PRINCE GEORGE'S LANHAM 5. Social Security Number 6. Sex Age (In yrs. last birthday)
74 Yrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 □ M 2 🗓 F Months Days Hours Min. DEC. 28 Director GEORGIA 253-74-2567 Usual Residence of Decedent show 10b. County 10a. State ms 23a or 28a-f sho must be notified at 10c. City, Town or Location death with the Maryland Director 10d. Inside City Limits 1 X Yes 2 □ No MD PRINCE GEORGE'S UPPER MARLBORO 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? Funeral 28 LAUGHTON STREET 20774 USA if item 27 is marked other than "natural", or items or other traumatic event, the Medical Examiner mu 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian Black, White, etc. Completed by 1 Never Married 2 Married be filed within 72 hours after 21215-0036 Specify: BLACK 1 Yes 2 X No Specify: If Yes. Give 3 ☐XWidowed 4 ☐ Divorced Year or Dates. 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Page 1 and 2 should be filed within 72 ment of Health and Mental Hygiene. ant: If item 27 is marked other than ' Elementary/Seconday (0-12) College (1-4 or 5+) 12TH O.R SECRETARY PRIVATE Be Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 CHESTER BUGGS CHARLIE M. GORDON Braswell 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) ROBERT BRASWELL/SON 11507 LOTTSFORD TERRACE BOWIE, MARYLAND 20721 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date permit. Page 1 Department of Important: If it any injury or o 1 X Burial 2 Cremation 3 4 Donation 5 Other (Specify) loval from State Ext. LINCOLN CEMETERY 4/9/2011 BRENTWOOD, MARYLAND 21 Signature of Funeral Service Lio 22. Name and Address of Facility J. B. JENKINS FUNERAL HOME, INC. 7474 LANDOVER ROAD HYATTSVILLE, MARYLAND 20785 23a. Part 1. Enter the disea death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Immediate Cause (Final Onset and Death Physician disease or condition resulting in death) SEPSIS Medical Due to (or as a consequence of): Examiner TYPE II DIABETES Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of) Hospital or Attending Physician: The law requires that the death certificate be executed use as the burial-transi Cause (Lisease or linjury ISCHEMIA CARDIOMYOPATHY s been signed by the attending physician and should be detached for use as the control of the state of the st that initiated events Due to (or as a consequence of) resulting in death) Last by Physician/Medical PERIPHERAL ATERIAL DISEASE Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery Ectopic pregnancy in the past 12 months?

1 Yes 2 No 4 Pregnant 9 Unknown Pregnant at time of death 5 Other (specify) Month Day Year 1 ☐ Yes 2 L 9 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 X No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an After this certificate has autopsy performed? Yes 2 X No 1 ☐ Yes 2X No 25. Was case referred to medica examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital 1 ☐ Yes 2 ☐XNo မြ 1 🔽 Inpatient 2 🗆 ER/Outpatient 3 🗆 DOA 27. Manner of Death Certificate: 28a. Date of injury 28b. Time of 28c. Injury at 28d. Describe how injury occurred (Month, Day, Year) X Natural 5 Pending iniury ☐ Accident work? 1 ☐ Yes 2 ☐ No Investigation Director: 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 24 hours Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 3 🗆 only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year, milem D00599 1311 2011 Mydelle " 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

State

Registrar

laverne

ABDELLA

MUKEMIL

31. Date filed (Month, Day, Year

APR 0 5 2011

F.

M.D.

32. Registra

12200 ANNAPOLIS ROAD SUITE 229

GLENN DALE, MARYLAND 20769

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.
State of Maryland / Department of Health and Mental Hygiene

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		- For State Registrar			_	Certifi	cate of l	Death					eg. No.		10	7:(5)
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ો Exami		PAU	L JASO	N BENNE	TT							March 27,				21291119
		4a. Facility Name (nd number)					ocation of I	Death		4c. County of Death Prince George's			
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21215-0036 nuld be filed within 7 Mental Hygiene. marked other than	Be	Oswa1d 19a. Informant's N			st \		19b. Mailing	Address	(Street	and Numb	per or Ru	ral Route Nu	mber, City	or Town,	State, 2	(ip Code)
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Baltimo permit. Page Department o Important: I		21. Signature of 5														ral Home
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of Vital Records, P.O ag Physician: The law requires that the true this certificate has been signed by ineral director, page 2 should be detect ineral director, page 2 should be detected.	d b											1				opsy findings available
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Vital Rec ysician: The l his certificate l director, page	B B	examiner?	_	Hospital	1 Inpatien	1 2 🗸 E	R/Outpatient	3 🔲 🛭	OOA	Other4	Nursing	g Home 5	Residen	ce 6	Other:	
1 of V ling Phys After thi funeral d	-	1 Yes 27. Manner of De	2 No	28	a. Date of Injury		8b. Time of I	nju r y :	28c. Injur	y at Work		28d. Describ		у оссите	d	
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Atter r dear ector by th	g	2 Accident		21	lar 27, 2011 Be. Place of Inju			et, factory	, office b	uilding, et	C.	28f. Location	(Street an	d Number	r or Rur	al Route Number, City
Division tal or Atteodit ts after death. al Director: A	Certification:	3 ☐ Suicide 4 ✔ Homicide	de	termined (Specify) Park	king Lot					le le	or Town 6806 Seat F	Pleasant [Orive , Se	eat Ple	asant, MD
lospit hour uner		29a. Certifier	Cortifuing	Physician: To	the best of my	knowledge	, death occu	rred at the	e time, da	ate and pla	ace, and	due to the ca	use(s) and	manner a	as state	d.
Division of Vital Records, P.O. Box 68: To the Hospital or Attending Physician: The law requires that the death certifi within 24 hours after death. To the Funeral Directory. After this certificate has been signed by the attending completely filled in by the funeral director, page 2 should be detached for use as	Sa	(Check only one) 2		kaminer:On th	e basis of exam	ination and	d/or investiga	tion, in m	y opinion	, death oc	curred a	t the time, da	te and plac	e, and du	e to the	cause(s)
To To To To To To To To To To To To To T	Medical	29b. Signature a	nd title of cert		nanner stated.			29	c. Licens	e number			29d. D	ate signe	d (Mon	th, Day, Year)
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2	1	30. Name and ac			int Medical			Penn St	treet, B	Baltimore	e, MD	21201				
		24 2 1 21 1 44			32. Register											
	State	■ JI. Date Hed (M	unui, Day I De	"/ <u>K</u>		7	BA A									

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Amend 23a per med cert G915.573/IF all Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death Reg. No-1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ MARCH 29 2011 ear DONALD LEE BRANNON 10:15 P M Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City. Town, or Location of Death 4c. County of Death **OUEEN ANNE'S** HOSPICE CENTER CENTREVILLE Social Security Number 7. Age (In yrs. last birthday) 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 XM 2 □ F Months Days Hours Min AUGnth, By, Year 925 TEETNOIS 85 Director 308-22-1401 Usual Residence of Decedent item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at be filed within 72 hours after death with the Maryland 10b. County 10c. City, Town or Location 10d. Inside City Limits Director MARYLAND QUEEN ANNE'S 1 Yes 2X No CHESTER 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Completed by Funeral 112 CHESSIE COURT 21619 UNITED STATES 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Forces?

1 XYes 2 No Black, White, etc 1 Never Married 2 XMarried Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: If Yes, Give 3-1946 Specify: WHITE 3 Divorced 4 Divorced 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) and Mental Hygiene. is marked other than Elementary/Seconday (0-12) College (1-4 or 5+) ELECTRICAL ENGINEER WESTINGHOUSE Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ္ HARRY C. BRANNON HAZEL CUTCHIN permit. Page 1 and 2 should be Department of Health and Men Important: If item 27 is marke any injury or other traumatic 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) HELEN L. BRANNON/ WIFE 112 CHESSIE COURT, CHESTER, MARYLAND, 21619 20b. PlaMATRYPOAND Name of 20a. Method of Disposition 20c. Location - City or Town, State APRIL 1, X Burial 2 Cremation 3 Removal from State VETERAN'S CEMETERY 4 ☐ Donation 5 ☐ Other (Specify) HURLOCK, MARYLAND 2011 21. Signature of Funeral Service Licens FELLOWS AND FEDERAL HOME, P.A. 408 S. LIBERTY ST., CENTREVILLE, MARYLAND, 21617 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Onset and Death Shock Physician/ Septic Medical resulting in death) Due to (or as a cons quence of): Examiner Peritonitis 2 weeks Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Examiner Due to (or as a consequence of) 2 weeks Perforated Intestine The law requires that the death certificate be executed the burial-transi that initiated events resulting in death) Last attending physician and Due to (or as a consequence of) Physician/Medical IF FEMALE 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) ____ in the past 12 months?
1 ☐ Yes 2 ☐ No Preanant at time of death Month P.O. signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ of Vital Records, Completed 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy certificate 1 ☐ Yes 2 ☐ No Yes Hospital or Attending Physician: 25. Was case referred to medical æ 26. Place of Death (Check only one) examiner? HOSPICE Certificate: To 2 **X** No Other: 4 Nursing Home 5 Residence 6 X Other (Sp 1 Inpatient 2 ER/Outpatient 3 DOA Director: After this 27. Mann of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending work' Division 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 1 Tes 2 No Investigation Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) within 24 hours a Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check only one 29b. Signatu 29d. Date signed (Month. Day, Year) D37064 30 Name and address of person who completed cause of death (Item 23a) (Type, Print) 115 Sallit D- Stevensville MO 2-1666 31. Date filed (Month 32. Registrar's Signature State 1 2011 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **2**8 Day Physician/ Month MARCH JOHN MARIA BYRNE 2011 10:45 PM Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death QUEEN ANNE'S CENTREVILLE CORSICA HILLS NURSING HOME If Under 1 Year If Under 24 Hrs. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** (Month, Day, Year) DEC - 25 - 1918 1 😿 M 2 🗆 F 92 Months Days Hours Min. NEW JERSEY Director 149-03-4333 Usual Residence of Decedent or 28a-f show notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director QUEEN ANNE'S CENTREVILLE MD 1X Yes 2 ☐ No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ò ral", or items 23a or Examiner must be Funeral USA 21617 111 S. LIBERTY ST., APT. 4 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Forces?

X Yes 2 \sum No Black, White, etc. 1 Never Married 2 Married Ś Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates, 1943–1946 1 ☐ Yes 2 X No Specify: "natural", 3 XWidowed 4 Divorced Specify: Completed WHITE injury or other traumatic event, the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) 2 should be filed within 72 in and Mental Hygiene.
7 is marked other than "r Elementary/Seconday (0-12) College (1-4 or 5+) **EDUCATION** 12 TEACHER Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ THOMAS STEPHEN BYRNE CATHERINE ROGERS 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 111 S. LIBERTY ST., APT.4, CENTREVILLE, MD 21617 JOHN S. BYRNE/ SON 1 and 2 s if Health item 27 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State MARCH 30, CHESAPEAKE CREMATION STEVENSVILLE, MD 4 Donation 5 Other (Specify) 2011 CENTER 21. Signature of Puneral Service Licens 22. Name and Address of Facility FELLOWS, HELFENBEIN & NEWNAM FUNERAL HOME, P.A. LIBERTY ST., CENTREVILLE, MD 2161 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on early line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition Medical resulting in death) Examiner Hears Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury law requires that the death certificate be executed 1alns that initiated events or as a consequence of) resulting in death) Last attending physician for use as the burial Physician/Medical Box 68760 yes, outcome of pregnancy
Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day Year Pregnant at time of death P.O. Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Division of Vital Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a, Was an autopsy director, page Hospital or Attending Physician: The 1 Yes 2 No 25. Was case referred medical Be 26. Place of Death (Check only one) examiner? 2 No မ 1 Inpatient 2 ER/Outpatient 3 IDOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred After injury 5 Pending To the Hospital or Attendia within 24 hours after death. To the Funeral Director: At completed filled in by the fu 1 ☐ Yes 2 ☐ No 2 Accident Investigation M 3 ☐ Suicide 4 ☐ Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined building, etc. (Specify) Medical 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier X 30. Name and address of person, who completed cause of death (Item 23a) (Type, Print) Regelmens Lane, Easton, MD 610 rinoley 31. Date filed (Month, Day, Year) 32. Registrar's Signature

State

Registrar

MAR 3 1 201

parke

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene. Certificate of Death Registrar Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death March March Physician/ 2011 Jack H Buckles 8:39 Рм Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Frederick Memorial Hospital Frederick Frederick 8. Date of Birth (Month, Day, Year) March 12,1923 Social Security Number If Under 1 Year If Under 24 Hrs. **Funeral** 7. Age (In yrs. last birthday, 9. Birthplace (State or Foreign 1 XM 2 □ F Days Hours Tennessee Director 226-26-9547 88 Usual Residence of Decedent ms 23a or 28a-f show must be notified at Page 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene.
ant: If item 27 is marked other than "natural", or items 23a or 28a-f sho. 10a. State 10b. County 10c. City, Town or Location Director Yes 2 No Frederick Frederick Maryland 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ural", or items 23a o Funeral 286 Pinoak Lane 21701 United States 12. Was Decedent Ever in U.S. Armed Forces? 1 X Yes 2 □ No WWII If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. þ 1 Never Married 2 X Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: 3 Divorced 4 Divorced Completed White Year or Dates other traumatic event, the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Steamfitter Construction Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ၉ James Buckles Jennie Massengill permit. Page 1 and 2 should Department of Health and M Important: If item 27 is mar any injury or other traumat 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1820 Latham Drive, Frederick, MD 21701 Billie Buckles / Wife 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 1 🔀 Burial 2 🗆 Cremation 3 🗆 Removal from State 4/1/2011 Frederick, Maryland 4 ☐ Donation 5 ☐ Other (Specify) Mt. Olivet Cemetery Stauffer Funeral Home . Sign war of Funeral Service License 22. Name and Address of Facility 1621 Opossumtown Pike, Frederick, MD 21702 23a Part 1. Enter the disease, or complications that cause the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, snock, or heart failure. List only one cause on each line. Immediate Cause (Final Onset and Death Physician/ robbli MINOCEVERICH disease or condition resulting in death) Medical Examiner Due to (or as a consequence of Florillation Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examiner Due to (or as a consequence of attending physician and for use as the burial-transit To the Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or linjury monno that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Division of Vital Records, P.O. Box 68760 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) in the past 12 months?
1 ☐ Yes 2 ☐ No Day Month Year Pregnant at time of death signed by the Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably Completed 4 Unknown Were autopsy findings available prior to completion of cause of 24a. Was an has autopsy perform death? within 24 hours after death.

To the Funeral Director; After this certificate ☐ Yes 2☐ No 1 Yes 2 25. Was case referred to medical funeral director, Certificate: To Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No 2 ER/Outpatient 3 DOA Inpatient Manner of Death 28a. Date of injury 28b. Time of 28c. Injury at 28d. Describe how injury occurred (Month, Day, Natural 5 Pending 1 🗌 Yes Investigation
6 Could not be Accident 3 Suicide 4 Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) Medical 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and que to the cause(s) and manner as the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check 29b. Signature and title of certifier 30/11 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 1564 possimtown 10 Asuncion 31. Date filed (Month. 32. Registrar's Signature State

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2 Date of Death $2\,6^{\text{Day}}$ Physician/ Month 201°1 5:30 PM Bernadetta Miss Brandenburg Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death **Examiner** Frederick Braddock Hgts. Vindobona Nursing Home 5. Social Security Number If Under 1 Year If Under 24 Hrs. 6. Sex 8. Date of Birth 9. Birthplace (State or Foreign 7. Age (In vrs, last birthday) Funeral Days Min 878 74 924 1 🗆 M 2 🕱 F Months Country) 220-18-3187 86 Yrs. Director Usual Residence of Decedent or 28a-f show notified at 10a. State 10c. City, Town or Location 10d. Inside City Limits Director 1 🗌 Yes 2 😿 No MD Frederick Middletown 0 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ber items 23a Funeral 7202 01d Middletown Rd. 21769 USA 12. Was Decedent Ever in U.S.
Armed Forces?
1 ☐ Yes 2 ☑ No
If Yes, Give
Year or Dates. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. "natural", or þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify: Completed 3 X Widowed 4 □ Divorced White Medical 15. Decedent's Education 16a Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life, DO NOT use retired) d 2 should be filed within 7: alth and Mental Hygiene.
127 is marked other than ar traumatic event, the ME Elementary/Seconday (0-12) College (1-4 or 5+) homemaker own home 6 Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ဂ္ Mary Flook Elmer S. Wiles 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 4140 Richard Remsburg Rd., Jefferson, permit. Page 1 and 2 sh Department of Health an Important: If item 27 is any injury or other trau Yolanda House (Daughter) 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 XBurial 2 Cremation | Removal from State Lutheran cemetery 4/2/2011 Middletown, MD 4 Donation 5 Other (Specify) of Funeral Service Lice 22. Name and Address of Facility Signa Donald B. Thompson Funeral Home 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, ck, or heart failure. List only one cause on each line. rt 1. Enter the disease Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ DEMENTIA disease or condition resulting in death) Medical Due to (or as a consequence of **Examiner** Sequentially list conditions, Examiner if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of) requires that the death certificate be executed use as the burial-transit Cause (Disease or linjury that initiated events resulting in death) Last Due to (or as a consequence of): attending physician Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?
1 ☐ Yes 2 ☐ No Day Pregnant at time of death Year be detached 1 ☐ Yes ∠ ☐ 9 ☐ Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Tes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an page 2 perform 1 Yes 2 No Yes 2 No To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifical completed filled in by the funeral director, I 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital 2 No Other: 1 \square Yes ၉ 1 Inpatient 2 ER/Outpatient 3 DOA 4X Nursing Home 5 ☐ Residence 6 ☐ Other (Specify, 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at work? 28d. Describe how injury occurred Natural
Accident
Suicide
Homicide 5 Pending 1 Yes 2 No Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined Medical 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one 29b. Signatu 29c. License number 29d. Date signed (Month, Day, Year) 00062223 Name and address of person who completed cause of death (Item 23a) (Type, Print)

LAYEEN BLALUM, 1967JILIVE, FLEDERICK, MD 21702 32. Registrar's Signature Year) State Registrar

Box 68760

P.O.

Records,

Division of Vital

Z	Amend	It	em # 9 Please	Type or Print in							•	
(4/05/	20	11 For rjw	State of Maryla					Mental Hy	giene	2011	12270
			Registra Cecil Cou	nty health	dept	Certifica	ate of l	Death	-T-	Reg. No	ZUII	12310
	Physicia Medi		1. Decedent's Name (First, Middle, La.	Wesley	-	oks			2. Date of De	ath Day	y 2 Year	3. Time of Death /: 35 PM
	Exami	ner	4a. Facility Name (if not institution, give	1 1 1 1 1	al Cer	4b. Ci	ty, Town, o BaHi	r Location of Deatl MOVE	n *	4c.	County of Dea	th
	Funeral Director		5. Social Security Number 6. S 212-42-3416 1	Sex 7. Age (In yr.	1-7	rday) If Und Month	der 1 Year s Days	If Under 24 Hrs. Hours Min.	8. Date of Bir (Month, Da SEPT 1	y, Year)		rthplace (State or Foreign
	T MO	١.	Usual Residence of Decedent							-		ryland
	nylanda-f sh	cto	10a. State 10b. County MARYLAND HARF		City, Town	or Location	****	- DE CD16	·			10d. Inside City Limits
	he Ma or 28a s notil	P	MARYLAND HARF	JRD			HAVKI Zip Code	E DE GRAC	E	10a Cit	izen of What C	1 X Yes 2 No
	ms 23a must be	Funeral Director	571 HALL O		11.0	140 W D		21078	ifVeNe-		UNITED	STATES
21215-0036	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	þ	11. Marital Status 1 Never Married 2 🕱 Married 3 Widowed 4 Divorced	12. Was Decedent Ever in Armed Forces? 1 ☐ Yes 2 X No If Yes, Give Year or Dates.	U.S.	If Yes, sp	ecify Cuba	lispanic Origin? (Span, Mexican, Puert Specify:	pecify Yes or No- o Rican, etc.)		14. Race - Ame Black, Whit Specify: B	
15-	72 ho n "nat fedica	Completed	15. Decedent's E (Specify only highest gr	ducation ade completed)	. 1	Decedent's Us (Give kind of w	vork done (during most of wor	king	16b. Ki	ind of Business	Industry
212	within giene. er tha		Elementary/Seconday (0-12)	College (1-4 or 5+)	'	life. DO NOT L CUS	STODIA			COT	JNTY GO	VERNMENT
	filed valued by a dother	Be C	17. Father's Name (First, Middle, Last)					18. Mother's Nar	ne (First, Middle,	Maiden S	Surname)	
yla	Ment Ment narke	<u> </u> 2	LUKE BROOKS					HARRIET	T MURRA	<u> </u>		
, Maryland	and 2 shou Health and tem 27 is n		19a. Informant's Name/Relationship (7, MARY A. BROOKS	*! ' '	19b.			and Number or Ru				ip Code) LAND 21078
Baltimore,	age 1 ar ent of He nt: If iter ry or oth		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Speci.	Removal from State	cemetery	Disposition (N y, crematory of CEMET	r other plac		Date 09/11		Cation - City or	
altii	permit. F Departm Importa any inju		21. Signature of Funeral Service Licens		i dans							
<u>m</u>	8 8 E 8 8	10.0	Wan Se	H- Colema	~	5	52 LE	ss of Facility COTT FUN WIS STRE	ERAL HON ET, HAVI	E DE	CA. E GRACE	_MD 21078
Į	Pnysician/ Medical		23a. Part 1. Enter the disease, or com shock, or heart failure. List only o Immediate Cause (Final disease or condition resulting in death)	a. Cereb	ral	enter the mo	nde of dyin	g, such as cardiac	or respiratory an	rest,		Approximate Interval Between Onset and Death
	Examiner	Į.	Sequentially list conditions, if any, leading to immediate	b. Hemor	rha	al .						1 hour
	ted I Insit	Examiner	cause. Enter Underlying Cause (Disease or linjury	Due to (or as a conse	1	M TOPE	10.00					4 days
	be executed sician and burial-transit		that initiated events resulting in death) Last	Due to (or as a conse			y11 0 -					
9	nte be hysicia he bur	dical		d								
Box 68760	To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. Of the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit	Physician/Medic	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	23c. If yes, outcome of preg 1 Live Birth 2 Fe 4 Pregnant at time of	etal death	3		ру			23d. Date of de Month	elivery Day Year
P.O.	ires that the dea signed by the a id be detached f	by Ph	Part II. Other significant conditions of	ontributing to death but not r	esulting in	the underlyin	g cause giv	ven in Part I.	23e. Did to			the cause of death?
ds,	/ requires been sig should b	ted							1 🗆 '	Yes 2	XNo 3□F	Probably 4 🗌 Unknown
Recol	sician: The law re certificate has be irector, page 2 sh	Completed							24a. Was autor perfo		prior to	utopsy findings available completion of cause of successions 2 \square No
<u></u>	ysician: is certifica director, I		25. Was case referred to medical examiner?	8				ace of Death (Chec				
Ξ	Physic this or al dire	유	1 ☐ Yes 2 ☒ No 27. Manner of Death	Hospital: 1 Inpatient 2				4 L Nursing H	ome 5 Resid		_	cify)
o uo	ending Frath. It: After he funer	Certificate:	1 Natural 5 ☐ Pending 2 ☐ Accident Investigation		28b. Tii inj	me of jury M	28c. Injun work 1 \square	y at ? Yes 2 🗌 No	28d. Describe h	ow injury	occurred	
Division of Vital Records,	To the Hospital or Attending F within 24 hours after death. To the Funeral Director: After is completed filled in by the funeral or the funeral birector.	al Certii	3 Suicide 6 Could not b 4 Homicide determined	28e. Place of Injury - At building, etc. (Spec		m, street, facto	ory, office		28f. Location (S City or Tow		l Number or Ru	ral Route Number,
	ne Hosp in 24 hot ne Funel pleted fil	Medical	(Check 2 Medical Exami only one) 3 Certifying Nurs	sician: To the best of my kno iner: On the basis of examinat se Practioner: To the best of	ion and/or my knowle	investigation, i	n my opinic curred at the	on, death occurred a e time, date and pla	at the time, date a ice, and due to the	nd place, e cause(s)	and due to the and manner as	cause(s) and manner stated.
	Vithi Vithi Co		29b. Signature and title of certifier	110		25	9c. License	number		29d. Date	e signed (Mont	h, Day, Year)
			1 There,	1412			00			140	1.1 2,0	×0//
			30. Name and address of person who of Matthew Llw	completed cause of death (Ite 32. Registrar's Sign	em 23a) (Ty	/pe, Print)	SM	ect 711	leinben	B	eltimor	c,MD 21201
	Stat Registra	te ar	31. Date filed (Month, Day, Year) APR 0 5 2011	32. Registrar's Sign	ature ar	KN			-			

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene) State Registrar Certificate of Death Reg. No 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month. **20 1** 2312 P M Gail D. Costen. Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death CIEMAI MANCUI 11150 If Under 24 Hrs 8. Date of Birth **Funeral** 9. Birthplace (State or Foreign (Month, Pay Year) 04/09/1960 1 □ M 2 💢 F Months Hours Min. Director 215-78-9664 Usual Residence of Decedent show ms 23a or 28a-f sho must be notified at 10a. State 10b. County filed within 72 hours after death with the Maryland Director 10c. City. Town or Location 10d. Inside City Limits orcester 1 Ves 2 No MD Pocomoke 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 6 Bradley St., 21851 **USA** items Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Was Decedent Ever in U.S. 14. Race - American Indian. Examiner Armed Forces Black, White, etc. Ь 1 Never Married 2 Married by Yes 2 1100 Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: If Yes, Give "natural", Specify 3 Widowed 4 Divorced Completed Black Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) ed other than " event, the Med Elementary/Seconday (0-12) Page 1 and 2 should be filed within ment of Health and Mental Hygiene. ant: If item 27 is marked other tha ury or other traumatic event, the I College (1-4 or 5+) Disabled Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Nathaniel Cropper Elsie Brittingham 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Calvin Costen / Husband 6 Bradley St., Pocomoke, MD 21851 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date permit. Page 1 Department of Important: If it any injury or o cemetery, crematory or other place 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) 4/9/2011 St. James U. M. Church Pocomoke, MD 21. Signature of Funeral 22. Name and Address of Facility 0. mule Cooper & Humbles Funeral Co., Inc., Accomac, VA 23301 Part 1. Enter the disease, or complice shock, or heart failure. List only one ions that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Interval Between Immediate Cause (Final Onset and Death Physician/ disease or condition resulting in death) FRACEMENT Medical Due to (or as a consequence of) Examine Sequentially list conditions Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of) Hospital or Attending Physician: The law requires that the death certificate be executed After this certificate has been signed by the attending physician and funeral director, page 2 should be detached for use as the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No Pregnant at time of death 5 Other (specify) Month Day Year Unknown Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an 24 hours after death.

Funeral Director: After this certificate has ! autopsy Yes 2 2 🗌 No 1 Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) 1 Yes 2 12 No Other: ပ 1 Inpatient 2 I ER/Outpatient 3 I DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at 5 Pending Natural 2 Accident
3 Suicide
4 Homicide 1 Yes 2 No Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check within 2 To the I only one 29b. Signature a nd title of dertifi 29c. License number 29d. Date signed (Month, Day, Year) 05355 - 01 ZO11 30. Name and address on who completed cause of death (Item 23a) (Type, Print) Salisbum MD 2180 Carrol Strect State gistrar's Signature. 0 Registrar

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Amended #8perFH/FCHD DC4/4/11 Continued of Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ March 2011 30, DELLA TOSCA CAREY 3:45 PMMedical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City. Town, or Location of Death 4c. County of Death Somerford Assisted Living Frederick Frederick If Under 1 Year | If Under 24 Hrs. Months | Days | Hours | Min. . Social Security Number 7. Age (In yrs. last birthday) Funeral 8. Date of Birth 9. Birthplace (State or Foreign 1 M 2 QF Months (Month, Day Year) Director 577-12-8926 89 Sept. Pennsylvania Usual Residence of Decedent Sept. 29, 1920 item 27: is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at 10a. State 10b County 10c. City, Town or Location 10d. Inside City Limits Director 1 😾 Yes 2 🗆 No Maryland Frederick Frederick 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? Funeral Brooklawn Apartments Apt. 118 21701 U.S.A. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. ģ 1 Never Married 2 Married 1 ☐ Yes 2 X No If Yes, Give 1 ☐ Yes 2 X No Specify. Completed 3 ₩ Widowed 4 Divorced White Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) al Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) Beautician Hair Salon Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) and Mental is marked o ပ Benjamie DiTheodore Anita DeLuca 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 st Department of Health a Important: If item 27 is any injury or other tra Sandra Thompson / Friend 2101 Foxfield Circle, Frederick, MD 21702 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 1 N Burial 2 ☐ Cremation 3 ☐ Removal from State Mary's Cemetery 4 ☐ Donation 5 ☐ Other (Specify) 4/2/2011 Petersville, Maryland ROBERT E. DAILEY & SON FUNERAL HOMES, 1201 NORTH MARKET STREET, FREDERICK, 21. Signature of Funeral Service Licenses 23a. Part 1. Enter the disease, or comp ions that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line Interval Between Immediate Cause (Final Onset and Death Physician/ disease or condition resulting in death) Medical Due to (or as a o lence of Examiner Sequentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of) and I-transit that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of) physician a Physician/Medical attending p IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?
1 ☐ Yes 2 ☐ No Month Pregnant at time of death Day Year 9 Unknown 9 Unknown signed by t d be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has page performe 2 🗌 No 1 Yes 2 25. Was case referred to medical funeral director, Be 26. Place of Death (Check only one) Hospital Other: 1 ☐ Yes 2 → No 읻 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence this Other (Specif 27. Manner of Death Natural 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred the Hospital or Attending I hin 24 hours after death. the Funeral Director: After injury 5 Pendina work?
1 Yes 2 No 2 Accident Investigation the 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) completed filled in by 4 Homicide determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner. To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check 3 To the I within 2 only one)

State Registrar

Baltimore, Maryland 21215-0036

Box 68760

P.O.

Records,

Division of Vital

DHMH 17 Rev 7/2009

29b. Signature and title of certifier

31. Date filed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Casper Cline, MD 300 West Ninth Street, Frederick, MD 21701

32. Registrar's Signature

mi

Barke

29c. License number

D16428

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ V. 29 Bay Mildred Cassidy 2011 March 11:38 A M Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Montgomery Casey House Hospice Care Rockville 8. Date of Birth (Month, Day, Yes Social Security Number If Under 1 Year | If Under 24 Hrs. **Funeral** 6. Sex Age (In yrs. last birthday, 9. Birthplace (State or Foreign Days Min. 1 M 2 X Hours Country) 183-24-4071 79 Director Pennsylvania Usual Residence of Decedent 28a-f show 10a. State 10b. County 10c. City, Town or Location Examiner must be notified at 10d. Inside City Limits Director Florida Lake 1 X Yes 2 No Lady Lake 10e. Street and Number 0 10f. Zip Code 10g. Citizen of What Country? , or items 23a Funeral 606 Enconto Street 32159 United States 72 hours after death 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S Armed Forces? 14 Race - American Indian Black, White, etc. 1 ☐ Yes 2 🛣 No If Yes, Give <u>Ş</u> 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: "natural", Completed 3 Widowed 4 Divorced White Year or Dates the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) permit. Page 1 and 2 should be filed within 72 Department of Health and Mental Hygiene. Important: If item 27 is marked other than 'any injury or other traumatic event, the Me Elementary/Seconday (0-12) College (1-4 or 5+ 12 Homemaker Own Home Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) John Milcic Bodanic Margaret 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Lawrence J. Cassidy / Husband 606 Enconto Street, Lady Lake, Florida 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place) 1 X Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) Gate of Heaven Cem. 4/2/2011 Silver Spring, Md. Name and Address of Facility
Muriel H. Barber Funeral Home
P. O. Box 5038, Laytonsville Signature of Funeral Service Licensee Roy Ba <u>Laytonsville</u>, 20882 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Immediate Cause (Final Onset and Death Physician, Lung Cancer disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of) the Hospital or Attending Physician: The law requires that the death certificate be executed burial-trans that initiated events resulting in death) Last and Due to (or as a consequence of): attending physician Physician/Medical Division of Vital Records, P.O. Box 68760 the IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death use 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) ____ in the past 12 months? page 2 should be detached for Month Pregnant at time of death the 9 Unknown g 🗌 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? ģ 1 Yes 2 No 3 Probably 4 Unknown Completed Were autopsy findings available 24a, Was an has autonsy prior to completion of cause of death? After this certificate 1 Yes 2 No Yes completed filled in by the funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital 2 🗹 No မ 1 Yes 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA Hospice 28a. Date of injury (Month, Day, Year) 27. Manner of Death 1 Natural 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 5 Pending iniury work? 1 ☐ Yes 2 ☐ No after death Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State, within 24 hours a Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 🗖 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b, Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) R 143201 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 20855 Debrah Miller, CRNP 6001 Muncaster Mill Road, Rockville, Md. egistrar's Signatur 32 State

Registrar

CHARA

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month Day ELSIE MAE HERBERT DeLOATCH Medical Orl 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Plato Civista Charles -a If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign Age (In vrs. last birthday 8. Date of Birth **Funeral** Days 1 M 2 X F 212-30-0569 78 1/Month 200, Year 9 3 2 Director Yrs Usual Residence of Decedent shov 10a. State 10b. County must be notified at 10c. City, Town or Location 10d. Inside City Limits filed within 72 hours after death with the Maryland Director WALDORF MD. CHARLES or 28a-f 1 🗆 Yes 2 🛣 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 20602 or items 23a 5401 WEDDING COURT U.S.A. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) permit. Page 1 and 2 should be filed within 72 hours after dea Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or iter any injury or other traumatic event, the Medical Examiner once. 11. Marital Status Was Decedent Ever in U.S. 14. Race - American Indian, Black, White, etc 1 Yes 2 No If Yes, Give Year or Dates. 1 Never Married 2 Married Completed by 1 ☐ Yes 2 X No Specify: Specify: BLACK 3 ¥ Widowed 4 □ Divorced 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) DOMESTIC ENGINEER SELF EMPLOYED 10th Be laryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) JOHN THOMAS HERBERT EVELYN DUVALL 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) JOYCE CARTER-DAUGHTER 5403 WEDDING CT. WALDORF, MD. 20602 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 1 ☐ Burial 2 【XCremation 3 ☐ Removal from State | cemetery, crematory or other place)
METROPOLITAN CREMATORY 4-14-11 ALEX., VA. 4 ☐ Donation 5 ☐ Other (Specify) M00479 Signature of Funeral Service Licensee RAYMOND FUNERAL SERVICE, P.A. LA PLATA, MARYLAND 20646 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between shock, or heart failure. List only one cause on each line Immediate Cause (Final Onset and Death Ph_sician/ disease or condition resulting in death) Medical Due to (or as a cons Examiner Sequentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-tran that initiated events resulting in death) Last Due to (or as Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No
9 ☐ Unknown 5 Other (specify) Month Dav Year Pregnant at time of death signed by the a Part II. Other significant conditions contributing to death but pot resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown been si 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an his certificate has be director, page 2 sl autopsy performe 2 🗌 No ☐ Yes 2 No 1 🗌 Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital: 2 No Other: 1 🗌 Yes ျ 1 Nnpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) this funeral 27. Manner of Death Certificate: 28a. Date of injury 28b. Time of 28c. Injury at 28d. Describe how injury occurred After (Month, Day, Year) 1 Natural 5 Pending work' 1 \square Yes 2 No Accident
Suicide within 24 hours after death

To the Funeral Director: /
completed filled in by the f Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifier (Check Certifying Nurse Practioner: To the best of my knowledge, death occ ed at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of 29d. Date signed (Month, Day, Year) . Name and address of person who completed cause of death (Item 23a) (Type, Print) 7C Post State

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Registrar

18

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			1 - For State Registrar 1. Decedent's Name (First, Middle, Lasi	State of Mar	yland / Dep	artment	of Health	h and Me th	ental Hygi	g. No.	12375
	Physic		MARIE CARDAREL						APRIL 1,	Day Year	
1	/Medi Examir		4a. Facility Name (If not institution, give			4b. City, To	own, or Location		THE T	4c. County of Dea	
			MAPLE RIDGE GROUP	HOME		ROCK	VILLE			MONTGOME	ERY
	Funeral Director		5. Social Security Number 6. Se 066-24-1979	7	In yrs. last birthday 81 Yrs.	If Under 1 Months	Year If Und Days Hour	der 24 Hrs. rs Min.	8. Date of Birth (Month, Day, Nov. 5	9. Bi 1929	rthplace (State or Foreign country) New York
	/land		10a. State 10b. County	1	Oc. City, Town or L	ocation					10d. Inside City Limits
	Man a-fsh	tor	Md. Montgo	mery	Silv	er Spr	ing				1 ☐ Yes 2 🛣 No
	or 28	Direc	10e. Street and Number			10f. Zip C	ode		10	g. Citizen of What C	ountry?
	s 23a	rail	3188 Adderley Cou				20906			United	
920	2 should be filed within 72 hours effer death with the Maryland and Mental Hygiene is marked other than "naturel", or Items 23a or 28a-f show eurnatic event, the Medical Eventrar must be contribed at	by Funeral Director	11. Marital Status 1 □ Never Married 2 ☒ Married 3 □ Widowed 4 □ Divorced	12. Was Decedent Eve Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates:	er in U.S. 13.		nt of Hispanic y Cuban, Mexi ≚No Spec		cify Yes or No- lican, etc.)	14. Race - Am Black, Wh Specify:	
21215-0036	72 ho	Completed	15. Decedent's Edu (Specify only highest grad	cation e completed)	(Give	edent's Usual of work	done during n	nost of working	g 1	6b. Kind of Business	s/Industry
121	within ene. then '	mpi	Elementary/Secondary (0-12)	College (1-4or 5+)	/ife.	DO NOT use	retired)				
2	filed Hygid other	ပိ	12 17. Father's Name (First, Middle, Last)	1	<u>_</u>	lomemak		other's Name	(First, Middle, M	Own Ho	ome
a	should be filed vand Mental Hygies marked other tumatic event. It	To Be	Joseph Cardarell	i				Elizabe		ione	
Maryland	s 1 and 2 should if Health and Men Item 27 is marke other treumatic	-	19a. Informant's Name/Relationship (T)			ing Address (S	Street and Nur	mber or Rural	Route Number,	City or Town, State,	Zip Code)
% ≥	of Health of Health litem 27 i		Elizabeth A. Hous					-		d, Maryla	
õ	Pages 1 nent of H int: If Ite		20a. Method of Disposition 1 ☐ Burial 2 🗹 Cremation 3 ☐ F	Removal from State	20b. Place of Disp cemetery, cre	osition (Name imatory or othe	of er place)	Da	_	Oc. Location - City o	r Town, State
Baltimore,	permit. Pages Department of Importent: If It any Injury or c		' 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licens	99	Metropol			4/1/2		Alexandr	ia. Va.
g	Depril Impo		PR ~ ()	20.1.00	2	Murie	1 H. Ba	arber E	Tuneral	Home	2222
			23a. Part1. Ener the disease, or compleshock, or heart failure. List only of	ications that caused the	e death. Do not en	ter the mode	of dying, such	as cardiac or	respiratory arres	ille, Md.	20882 Approximate Interval Between
	Physician		Immediate Cause (Final disease or condition	Sepsi	İs						Onset and Death
	/Medical Examiner		resulting in death)	Due to (or as a co							
		-0	Sequentially list conditions,	Due to (or as a co							
	uted d ansit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause Useaso or injury that initiated events		31,304,301,301,31,31						I
o^	ate be executed hysician and the burial-transit	Еха	resulting in death) Last	Due to (or as a co	onsequence of):						
68/6U ,	ate be hysici	lical		ı							
. Box	w requires thet the death centificate been signed by the attending physi should be detached for use as the	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☑ No 9 ☐ Unknown	3c. If yes, outcome of p 1 □ Live birth 2 □ 4 □ Pregnant at tim 9 □ Unknown	Fetal death 3	□Ectopic preg □ Other (spec				23d. Date of de Month	blivery Day Year
J.	requires thet the	by Ph	Part II. Other significant conditions con	ntributing to death but n	ot resulting in the u	inderlying cau	se given in Pa	ırt I.	23e. Did toba	cco use contribute t	to the cause of death?
Records,	aquire: en sig ould b		Alzheimer's Dise	ease					1 ☐ Yes	2 □ No 3 □ P	robably 4 🗹 Unknown
ပ	e law re has bec	Completed							24a. Was an autopsy	24b. Were a	utopsy findings available completion of cause of
	Th ate pag	Con							performe	ed? death?	
VII	yelcien: Th is certificate director, pag	Be	25. Was case referred to medical examiner?	lospital:			04		Check onl one		Assisted
5	Phye	. To	1 ☐ Yes 2 ☑ No ☐ ☐ ☐ ☐ Yes 2 ☑ No ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐	1 Inpatient 28a. Date of Injury	2 ER/Outpatie		Other: 4 i. Injury at		e 5 Residen	ce 6 Other (Special	Jiving
VISION	nding Phy th. :: After thi e funeral	ation	1 Natural 5 Pending 2 Accident investigation	(Month, Day Ye	ear) Injury	м	Work? 1 ☐ Yes 2			injury occurred	
<u> </u>	er deg rector	Certification:	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury building, etc. (5	- At home, farm, st	reet, factory, o	office	28	If. Location (Stre	et and Number or F	lural Route Number,
5	ital or irs aft rel Di										
	To the Hospital or Attending Physicien: which 24 hours after death. To the Funerel Director: After this certific completely filled in by the funeral director,	edicai	29a. Certifier 1 Certifying Physics (Check only one)	sician: To the best of m ner: On the basis of exa and manner stated	amination and/or in	h occurred at vestigation, in	the time, date my opinion, d	and place, and death occurred	d due to the cau d at the time, dat	ise(s) and manner a e and place, and du	s stated. e to the cause(s)
	To To To E	Σ	29b. Signature and title of certifier				icense numbe		290	d. Date signed (Mon	
			1 chiloso				D 3233	2		Apri	1 1, 2011
	5		30. Name and address person o co Suresh K. Gupta, M			•	C 4 - L	220 0	41 C		20000
	Sta	te	31. Date filed (Month, Day, Year)	32. Registrar's	Signature -			220, S	iiver S	oring, Md	. 20902
	Registra	- 2	APR na 2	1911 Dener	u D.	backs					

		For State Registrar	State of M	laryland / Der	oartment of ertificate of		nd Mental Hy	711	11 1237	16
Physicia	n/	1. Decedent's Name (First, Middle, La	,		oruncate or	Doutin	2. Date of De		3. Time of Dea	
Medic	al	Mewded 4a. Facility Name (if not institution, given		Debela 	4b. City, Town,	or Location of	April	3, 20	9:45 A	М.
		Montgomery Hos			Ro	ckville	2	Мо	ontgomery	
Funeral Director			Sex 1 □ M 2 X F	ge (In yrs. last birthday 34 Yrs.	Months Day			th ay, Year) 1976	g. Birthplace (State or For Country) Ethio Addie Ababa,	pi a
d d	r	Usual Residence of Decedent 10a. State 10b. County		10c. City, Town or L	acetion		OUI) 2	, 15,0		
farylan 8a-fsh tified a	ecto	Maryland Montgo	mery	-	ver Sprin	ıg			10d, Inside City Li 1 X Yes 2	
th with the Maryland ms 23a or 28a-f show must be notified at	Funeral Director	10e. Street and Number 3608 Bel Pre Roa	d; Apt. 14	•	10f. Zip Code 2090			10g. Citizen of V Ethio		
Baltimore, Maryland 21215-0036 permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mentall Hygiene. Department of Health and Mentall Hygiene. any injury or other traumatic event, the Medical Examiner must be notified at once.	þ	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced 15. Decedent's	12. Was Decedent Armed Forces? 1 ☐ Yes 2 ☑ If Yes, Give Year or Dates.	No	. Was Decedent of If Yes, specify Cu 1 Yes 2 N edent's Usual Occi	lo Specify:	n? (Specify Yes or No- Puerto Rican, etc.)	Specify:	e - American Indian, ck, White, etc. EThiopian	
1215 hin 72 h ne. than "n	Completed	(Specify only highest g Elementary/Seconday (0-12)	rade completed) College (1-4 or	(Giv	e kind of work done DO NOT use retire	e`during most o. d)	f working	1	usiness Industry	
Aaryland 21215 should be filed within 72 and Mentall Higher is marked other than "r	To Be C	12th grade 17. Father's Name (First, Middle, Last,			Homemake	18. Mother's	s Name (First, Middle,	Maiden Surname	Oomestic	
Maryland 2 should be filed Ith and Mental Hy 27 is marked oth traumatic event			Type Print)	- Jah Mai	ling Addross (Ctros			man ————————————————————————————————————	Made 71- Ondal 2006	
md 2 sh ealth a m 27 is		19a. Informant's Name/Relationship. Yohannes Haile E Ephrem Debela (E	egashaw (F Frother)	lusband) Mai	Bel Pre	Road;Ap	ot.14;Silv	er Sprin	ng,Maryland	
Baltimore, Misper and 2 st permit. Page 1 and 2 st Department of Health a Important: If item 27 any injury or other transonce.		20a. Method of Disposition 1 X Burial 2 ☐ Cremation 3		,	ematory or other pl	ace) Ap	ori1 9,201	1	City or Town, State	
Baltin permit. Pe Departme Importan any injury		4 Donation 5 Other (Spec			Church C				baba,Ethiopi ny Mortician	
		Jandshh	B. Her		Inc.;600	Kennedy	Street,N	.W.;Wash	ington,D.C.2	-
Physician/		23a. Part 1. Enter the disease, or cor shock, or heart failure. List only Immediate Cause (Final disease or condition	one cause on each lin	d the death. Do not er e. Myeloid L o		ing, such as ca	rdiac or respiratory ar	rest,	Approximate Interval Betweer Onset and Death	
Medical Examiner		resulting in death)	Due to (or as	a consequence of):						
D to	niner	Sequentially list conditions, if any, leading to immediate	b. Due to (or as	a consequence of):						
'60 ate be executed physician and the burial-transit	dical Examiner	Cause (Disease or iinjury that initiated events resulting in death) Last	c. Due to (or as	a consequence of):						
60 ate be e	dical		■ d							
ath certifica	-	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☒ Unknown	23c. If yes, outcome 1 Live Birth 4 Pregnant a 9 Unknown	2 Fetal death 3	Cother (specify)	ncy		23d. Dat Mor	te of delivery nth Day Year	
s that the designed by the abe detached		Part II. Other significant conditions			underlying cause of	given in Part I.			ibute to the cause of death?	
ords,	ed	Acquired Immuno	deficiency	Syndrome	~		1 🗆	Yes 2 🔀 No	3 Probably 4 Unkn	own
Records, The law requires cate has been sig	Completed by						24a. Was autor perfo	osy p ormed? d	Were autopsy findings availa prior to completion of cause death? □ Yes 2 □ No	of
/ital Residents The certificate	Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 ※No	Hospital:		l Ot	la	Check only one)	•	C II	
Division of Vital tal or Attending Physician: rs after death. al Director: After this certific ed in by the funeral director.	cate: To	27. Manner of Death 1 X Natural 5 Pending 2 Accident Investigation	28a. Date of inju (Month, Da	ent 2 ER/Outpatie ry 28b. Time o injury	of 28c. Inju	ıry at rk?	28d. Describe h	dence 6A Othe	er (Specify) Casey H	ous
Jivision of Attendiates after death Director: A	Certificate:	3 Suicide 6 Could not 1 4 Homicide determined	28e. Place of Inju	De la casa de la casa					er or Rural Route Number,	
Division o To the Hospital or Attending I within 24 hours after death. To the Funeral Director: After completed filled in by the funer	Medical	(Check 2 L Medical Exam	rsician: To the best of niner: On the basis of e	xamination and/or inve	stigation, in my opin	ion, death occur	rred at the time, date a	nd place, and due	to the cause(s) and manner:	stated.
To th within	— г	29b. Signature and title of certifier	Will	mp	29c. Licen			29d. Date signed	(Month, Day, Year) 3, 2011	
N- 2		30. Name and address of person who	•		*	_ 16277	D==1-P==1		1 1 00055	
State	9	Steven Wilks, M. B1. Date filed (Month, Day, Year) APR 14 2011				r Mill	Koad; Kock	ville,Ma	iryiand 20855	
Registra	r	APR 0 4 ZUIT	General 1	ary Signature						

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend #10a-f Per INF G916 6/16/2011 III. State of Maryland Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death 51120 NDO Physician/ Month 1345 M Medical 4a. Facility Name (if not institution, give street and number, 4b. City, Town, or Location of Death Examiner 4c. County of Death ANNE ARUNDEL MEDICAL CENTER ANNAPOLIS ANNE ARUNDEL If Under 1 Year If Under 24 Hrs. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 □ M 2 🗷 F Months Days Hours Min AUG. B, 1 406-50-9770 KENTUCKY Director 72 Yrs. 1938 Usual Residence of Decedent 28a-f shov at 10a OHIO 10c. City, Town or Location 10d. Inside City Limits Director Franklin Medical Examiner must be notified Yes 2 No **MARYLAND** ANNE ARUNDEL **ANNAPOLIS** Westerville 10e. Street and Number 7785 Club Ridge Riad 0 10f. Zip Code 10g. Citizen of What Country? Funeral 23a 43081 2813 BERTH TERRACE -21401UNITED STATES Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S 14. Race - American Indian. Armed Force Black, White, etc. 1 Yes 2 No If Yes, Give 9 þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🔼 No Specify: Specify: WHITE "natural", 3 Widowed 4 Divorced Completed Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) College (1-4 or 5+) Elementary/Seconday (0-12) traumatic event, the ARTIST DESIGN OF FASHION and Mental Hygie is marked other Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ဂ CHESTER LEE CALDWELL ETHEL ANN MILLER 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) f Health aitem 27 i permit. Page 1 and 2 Department of Health Important: If item 27 any injury or other tr LUIS DANIEL ELIZONDO / SON 405 FIVE FARMS DR. STEVENSVILLE, MARYLAND 21666 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State cemetery, crematory or other place) APRIL 4 4 Donation 5 Other (Specify) STEVESNVILLE CEMETERY STEVENSVILLE, MARYLAND 2011 22. Name and Address of Facility
FELLOWS, HELFENBEIN & NEWNAM FUNERAL HOME P.A.
106 SHAMROCK ROAD, CHESTER, MARYLAND 21619 21. Signature of Funeral Service Licensee 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Ops4t and Death Immediate Cause (Final Physician/ disease or condition Medical resulting in death) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Examine sician and burial-tran resulting in death) Last Physician/Medical law requires that the death certificate be the attending pl 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 3 Ectopic pregnancy

5 Other (specify) IF FEMALE: 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?
1 ☐ Yes 2 ☐ No ed by the a 1 ☐ Yes 2 ☐ 9 ☐ Unknown Unknown signed l Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by Completed 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available 24a. Was an autopsy performed? Yes 2 No prior to completion of cause of death?

1 Yes 2 No B B 25. Was case referred to medical director 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No ျှ ✓ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA this completed filled in by the funeral 27. Manner of Death Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? Certificate: 28d. Describe how injury occurred Hospital or Attending injury 1 Natural 5 Pending s after death. 1 Yes 2 No 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) e Funeral E Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation in proceedings. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To, the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check To the I within 2 only one) 29b. Signature and title of contific 29d. Date signed (Month, Day, Year) Name and address of person who completed cause of death (Item 23a) (Type, Print) ENTA M APOLO 441 :la ENSE 31. Date filed (Month, Day, Year) 32. Registrar's Signature Registrar

68760

Box (

P.O.

Records.

Division of Vital

Medical Examiner

Funeral Director

Physician/

Director

Funeral

Pla	assa Tvi	ne or Print i	n Bla	ck Indelible	ink En	CUTA	All C	nic	e Arol	oaib	lo.		
1- For State Registrar	St	ate of Maryl	and / I	Department of Certificate of	of Health	n and	Menta	al H	ygiene	Reg. N	20	Makalen s	12378
	Avery	Fisher							2. Date of De Month March 3	Dav			3. Time of Death 1045 hrs
4a. Facility Name (8413 Old O	4b. City, To Whale		ocation of	Death	4c. County of D Worcester								
5. Social Security N	356	6. Sex 1 X M 2 F	7. Age (1	In yrs. last birthday) Yr	If Under Months	1 Year Days	If Under	24Hrs. Min.	_			9. Birth Foreign Coul	
Usual Residence o 10a. State MD	f Decedent 10b. County Worces	ster	10	c. City, Town or Loca									10d. Inside City Limits 1 Yes 2 X No
10e. Street and Number						10f. Zip Code					itizen of Wha	at Count	
8413 Old Ocean City Blvd. 21872 USA 11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No- I ★ Never Married 2 Married 12. Was Decedent Ever in U.S. Armed Forces? 14. Yes 2 No specify: Specify: White 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done 16b. Kind of Business/Industry 16b. Kind of Business/Industry 16b. Kind of Business/Industry 16c. No. 16c. No. 16c. 1													

Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Fleath and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show injury or other traumatic event, the Medical Examiner must be coeffied at socc.

Physician /Medical Examiner

To the Hospital or Atteoding Physician: The law requires that the death cartificate be executed within 24 hours after death.

To the Fuoeral Director: After this certificate has been signed by the attenting physician and completely filled in by the funeral director, page 2 should be detached for us, as the burial - transit Division of Vital Records, P.O. Box 58760,

Med

State

Registrar

29b.-Signature and title of certifie

Zabiullah Ali, M.D.

Day, Year)

APR 0

31. Date filed (Month,

β	3 Widowed 4 Divorced If Yes, Give Year Marines	1 Yes 2 No specify:	Specify: whit	e
Completed by	15. Decedent's Education (Specify only highest grade completed)	16a. Decedent's Usual Occupation (Give kind during most of working life. DO NOT use	of work done 16b. Kind of Business/I	ndustry
plet	Elementary/Secondary (0-12) College (1-4 or 5+)			
E	12 17. Father's Name (First, Middle, Last)	waterman/ boat capta		
BeC			me (First, Middle, Maiden Surname)	
TOB	William Adolf Fisher 19a. Informant's Name/Relationship (Type, Print)	Ruby F	rancis Kelley	T. O
ř	Robery Avery Young	150 Allen Ave. Laure		Zip Code)
		lace of Disposition (Name of cemetery,	Date 20c. Location - City or	Four State
	1 Burial 2 Cremation 3 Removal from State	rematory or other place)		TOWIT, State
			5/2011 Greenbackvi	.11e VA
	21. Sonature of Full Service Licen	22. Name and Address of Facility T	he Burbage Funeral F	lome
_	I sural	108 William St.	Berlin, MD 21811	
	23a. Fart I. Enter the disease, of complications that daused the death. failure. List only one cause on each line.	Do not enter the mode of dying, such as cardia	c or respiratory arrest, shock, or heart	Approximate Interval Between Onset and
	that the same of t	scular Disease Complicated by Hyp	oothermia	Death
	or condition resulting in death) Due to (or as a consequence of	:	-	
9	Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of			
i i	cause. Enter Underlying Cause			
xar	(Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of)	:		
a E	d			
Be Completed by Physician/Medical Examiner	UNPENDED AMENDED			
/Me	IF FEMALE: 23b. Was decedent pregnant in the	ancy	23d. Date of delivery	
ian	past 12 months?	2 Fetal death 3 Ectopic preg	nancy Month D	ay Year
/sic	1 Yes 2 No 9 Unknown 9 Unknown	th 5 Other (Specify)		
P	Part II. Other significant conditions contributing to death but not res	sulting in the underlying cause given in Part I	23e. Did tobacco use contribute to ti	ne cause of death?
þ	<u> </u>	g g g g g	1 Yes 2 No 3 Proba	
ted				opsy findings available
e d			autopsy prior to co	mpletion of cause of
팃			performed? death? 1 Yes 2 No 1 Yes	2 No
98	25. Was case referred to medical examiner?	26.Place of Death (Chec	k only one)	
اق	1 Yes 2 No	R/Outpatient 3 DOA Other Nurs	sing Home 5 Residence 6 🗹 Other:	Scene
Ë	(Month, Day, Year)	28b. Time of Injury 28c. Injury at Work?	28d. Describe how injury occurred	tomporaturos
atie		FOUND: 1 Yes 2 No	Subject exposed to cold amient	temperatures
읦		ne, farm, street, factory, office building, etc.	28f. Location (Street and Number or Rura	al Route Number, City
Certification: To	4 Homicide determined (Specify) Residence		or Town, State) 8413 Old Ocean City Blvd, Whaleyv	lle, MD
cal	29a. Certifier 1 Certifying Physician: To the best of my knowledge			
.≃	one) a Medical Examiner: On the basis of examination and	Vor investigation, in my oninion, death occurred	at the time date and place, and due to the	cauca(c)

29c. License number

O.C.M.E.

111 Penn Street, Baltimore, MD 21201

DH 7+1

and manner stated

Assistant Medical Examiner

32. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a)

29d. Date signed (Month, Day, Year)

April 1, 2011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene ? Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ 4:31M Blair L. Fetzer Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Allegany Cumberland ∂MRM 9. Birthplace (State or Foreign Country) Pennsylvania 8. Date of Birth (Month, Day, Yea May 14, Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. Funeral Hours 1 X M 2 □ F **Director** 213-32-2739 7.5 Usual Residence of Decedent show 10c. City, Town or Location 10d. Inside City Limits permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked of other than "natural", or items 23a or 28a-f sho arry injury or other traumatic event, the Medical Examiner must be notified at. 10a. State 10b. County Director 1 🗌 Yes 2 😾 No MD Cumberland Allegany 10e. Street and Number 10g. Citizen of What Country? Funeral 500 Magruder Street 21502 USA 12. Was Decedent Ever in U.S. Armed Forces? 1 X Yes 2 ☐ No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status Black, White, etc. ģ 1 Never Married 2 X Married Maryland 21215-0036 1 ☐ Yes 2 🗓 No Specify: Specify: white Completed 3 Widowed 4 Divorced 155-57 Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) safety supervisor trucking Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Grace Ellen Yearick Blair LeRoy Fetzer Sr 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 21502 Merle S. Fetzer/spouse 500 Magruder Street Cumberland, MD Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 X Donation 5 Other (Specify) State Anatomy Board 655 W. Baltimore Street Director Baltimore, 21201 MD Part 1. Enter the disease, of complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, a heart failure. List only one cause on each line. Approximate Immediate Cause (Final disease or condition Physician/ Medical resulting in death) LOSCLEROTIC CARDIOVASCULAR DISTAS Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examir physician and s the burial-transit Cause (Disease or linjury Hospital or Attending Physician; The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 attending p IF FEMALE: yes, outcome of pregnancy
Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No 4 Pregnant 9 Unknown Pregnant at time of death Other (specify) sate has been signed by the a page 2 should be detached f Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by 2 No 3 Probably 4 Unknown Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of autopsy performed 1 ☐ Yes 2 ☐ No within 24 hours after death.

To the Funeral Director: After this certific completed filled in by the funeral director, 25. Was case referred to medica 26. Place of Death (Check only one) Be examiner? Other: 1 Yes 1 Impatient 2 ER/Outpatient 3 DOA ၉ 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: injury work? 1 Natural 5 \square Pending 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical Ecrtifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier

State Registrar 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

29b. Signature and title of certifier

Lamn 12500 Willowbrook Road Cumberland, Maryland Registrar's Signatu

29c. License number

1

DHMH 17 Rev 1/2001

OCME 2006

State

Registrar

29b. Signature and title of certifie

Melissa Brassell, MD

OCME

30. Name and address of person who completed cause of death (Item 23a)

Assistant Medical Examiner

Pegistrar's Signature

ORIGINAL

29c. License number

O.C.M.E.

111 Penn Street, Baltimore, MD 21201

29d. Date signed (Month, Day, Year)

April 9, 2011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene, for State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2 Date of Death 3. Time of Death ^{Day}2<u>011</u> Month Physician/ Joseph Harter Goff March 30, 3:00 P M Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Frederick Northampton Manor Care & Rehab Center Frederick If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign 6. Sex 7. Age (In vrs. last hirthday) 8. Date of Birth Social Security Number **Funeral** (Month, Day, Year) 931 Hours 1 🔯 M 2 🗀 F West Virginia 236-44-9089 Director Usual Residence of Decedent 10b. County 10a, State 10c. City, Town or Location 10d. Inside City Limits the Maryland Director notified 28a-f 1 X Yes 2 No Frederick Frederick Maryland P 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? items 23a or ner must be n Funeral United States 21701 200 East 16th Street 12. Was Decedent Ever in U.S.

Armed Forces?

1 ☑ Yes 2 □ No 1948If Yes, Give
Year or Dates. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black, White, etc. ō þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 permit. Page 1 and 2 should be filed within 72 hours after Specify: White 1 ☐ Yes 2 X No Specify. "natural" Completed 3 Widowed 4 Divorced 1951 Health and Mental Hygiene. tem 27 is marked other than "natur other traumatic event, the Medical. 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Construction Laborer Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ David A. Goff Goldie May Robinson 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1241 Grandview Ave., Akron, OH Clara V. Goff / Wife other 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a Method of Disposition 20c. Location - City or Town, State Department of H Important: If ite any injury or ot once, ApriDate 2 1 ☐ Burial 2 🛣 Cremation 3 ☐ Removal from State Frederick, Maryland 2011 Resthaven Crematory 4 Donation 5 Cther (Specify) ice License 21. Signature Skkot Cody P.A. Frederick, MD 21701 Resthaven Funeral Services, 9501 Catoctin Mountain Hwy. 23a. Part 1. Enter the dise shock, or heart failur , or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, List only one cause on each line. Interval Between Immediate Cause (Findisease or condition resulting in death) Onset and Death Ph_sician/ neumonia Medical Due to or as a consequence of) Examiner Sequentially list conditions. Examine if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of) igned by the attending physician and be detached for use as the burial-transit Hospital or Attending Physician; The law requires that the death certificate be executed Cause (Disease or Illilury that initiated events resulting in death) Last Due to (or as a consequence of) Completed by Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live Birth 2 Fetal death 23d Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy 5 Other (specify) in the past 12 months? Month Year Pregnant at time of death 2 No 1 Yes 2L 9 Unknown 9 Unknown signed by 1 Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 No 3 Probably 4 Unknown 1 Yes Were autopsy findings available prior to completion of cause of death? 24a. Was an within 24 hours after death.

To the Funeral Director: After this certificate has I completed filled in by the funeral director, page 2 s autopsy performed? Yes 2 No 1 Yes 2 No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Hospital: Other: 2X No မှ 1 Tes 1 Inpatient 2 ER/Outpatient 3 DOA 4 🕅 Nursing Home 5 □ Residence 6 □ Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred work?
1 \(\sum \) Yes 2 \(\sum \) No iniury X Natural 5 Pending 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) Medical 1 🔀 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only or 29d. Date signed (Month, Day, Year) April 1, 2011 29b. Signatui nd title of certifier 29c. License number D 51643 4+1 Name and address of person who completed cause of death (Item 23a) (Type, Print) Day, Year strar's Signature State 0

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death April **Physician** 2011 6:05 ам Edna Mae Harbin /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death Examiner Howard Ellicott City Encore Turf Valley 8. Date of Birth (Month, Day, Year) 07/20/1921 If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Months Days Hours 1 □ M 2 🕱 F 219-30-3276 MT Director 89 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County 28a-f shov 27 Is marked other than "natural", or items 23a or 28a-f shor traumatic event, the Medical Examinar must be notified at 1 ☐ Yes 2 X No Director Ellicott City MD Howard 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? permit. Pages 1 and 2 should be filed within 72 hours after death with t Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or any lujury or other traumatic event, the Medical Examinat rougher once. 9944 Old Frederick Road 21042 United States Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 Tyes 2 No Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No If Yes, Give Year or Dates: Specify: þ Specify: White 3 X Widowed 4 ☐ Divorced Completed 16a, Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) Own Home Homemaker 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Fred Williams Jean Harbin 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Kim Taylor - grand-daughter 10233 Green Clover Drive Ellicott City, MD 21042 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 20a. Method of Disposition 1 ☐ Surial 2 ☐ Cremation 3 ☐ Removal from State Crest Lawn Mem. Grdns. 04/07/2011 Marriottsville, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Harry H. Witzke's Family F.H.Inc. 21. Signature of Funeral Service Licensee 4112 Old Columbia Pike Ellicott City, MD 21043 mo 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Chronic Obstructive Pulmonary Disease /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, loading to initial discause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Date to for as a consequence of Examine certificate be executed burial-transit and Due to (or as a consequence of) Box 68760. attending physician for use as the buria Physician/Medical 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 🗷 No Month Day Year Pregnant at time of death 5 ☐ Other (specify) signed by the a d be detached f P.0. 9 Unknown 9 Unknown Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, ģ 1 ☐ Yes 2 X No 3 ☐ Probably 4 ☐ Unknown page 2 should Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a, Was an has autopsy certificate 1 ☐Yes 2 ☐No 1 ☐ Yes 2 **X**lo funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner' Other: 4 M Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To this 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of After t 28c. Injury at Work? 28d. Describe how injury occurred or Attending 1 🔀 Natural 5 Pending e Hospital or Attendir 124 hours after death. Ie Funeral Director: A 1 ☐ Yes 2 ☐ No 2 Accident investigation the 6 Could not be determined 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 ☐ Homicide 29a, Certifier 🖾 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical completely 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) within 2. the 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 29c. License number: April 4, 2011 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar

DHMH 17 Rev 1/2001

State

Dr. Lazris
31. Date filed (Month, De

05

Columbia, MD

21044

6334 Cedar Lane #103

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ MARCH 29 2011 MATTIE R. HAYES 2:02 P Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner WASHINGTON ADVENTIST HOSPITAL TAKOMA PARK MONTGOMERY . Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Months Days Hours JUNE 4 SOUTH CAROLINA Director 578-22-7219 94 Usual Residence of Decedent or 28a-f show notified at 10a. State 10c. City, Town or Location 72 hours after death with the Maryland 10d. Inside City Limits Director 1 Yes 2 No PRINCE GEORGE'S NEW CARROLLTON 10e. Street and Number 10f. Zip Code 2 10g. Citizen of What Country? ed other than "natural", or items 23a o event, the Medical Examiner must be Funeral USA 5712 85th AVENUE 20784 12. Was Decedent Ever in U.S. 13, Was Decedent of Hispanic Origin? (Specify Yes or No-11. Marital Status Race - American Indian Armed Forces If Yes, specify Cuban, Mexican, Puerto Rican, etc. Black, White, etc þ 1 Never Married 2 Married ☐ Yes 2X No 21215-0036 Specify: BLACK If Yes, Give 1 ☐ Yes 2 ☐XNo Specify: 3 Widowed 4 Divorced Completed Year or Dates Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) permit. Page 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: If item 27 is marked other than any injury or other traumatic event, the Merian injury or other traumatic event, the Merian injury or other traumatic event, the Merian injury or other traumatic event, the Merian injury or other traumatic event, the Merian injury or other traumatic event, the Merian injury or other traumatic event, the Merian injury or other traumatic event injury Elementary/Seconday (0-12) College (1-4 or 5+) PRIVATE NURSE Be Baltimore, Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ၀ COVINGTON PRUDENCE ALEXANDER PEGUES 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code 11416 CROOM ROAD UPPER MARLBORO, MARYLAND 20772 VIVIAN WILLIAMS/DGT. 20a. Method of Disposition
1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date LAUREL, MARYLAND 4 Donation 5 Other (Specify) MD NATIONAL CEME. 4/5/2011 J. B. JENKINS FUNERAL HOME, INC. 21. Signature of Funeral Service Licenses 22. Name and Address of Facility 7474 LANDOVER ROAD HYATTSVILLE, MARYLAND 20785 23a. Part 1. Enter the disease, or complications that caused the h. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line Immediate Cause (Final Physician disease or condition Medical resulting in death) Due to (or is a consequen a of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examiner Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or iinjury burial-transi and that initiated events resulting in death) Last Due to (or as a cd signed by the attending physician d be detached for use as the book Physician/Medical Division of Vital Records, P.O. Box 68760 yes, outcome of pregnancy

Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery Ectopic pregnancy in the past 12 months? Month Day Year Pregnant at time of death 5 Other (specify) Yes ☐ Yes ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 ☐ Probably 4 ☐ Unknown been 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed After this certificate has page 2 2 🔀 No 1 Yes Yes funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital: Other: ပ 1 Tyes Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) Manner of Death 28b. Time of 28a. Date of injury 28c. Injury at work? 1 \(\text{Yes} Certificate: 28d. Describe how injury occurred (Month, Day, Year) iniury Natural 5 Pending 2 🗆 No hours after death uneral Director; / Accident Investigation the Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, filled in by Homicide determined City or Town, State) 24 hours a Funeral I Medical 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. сотретер Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check within 2 To the F only one) 29b. Signature and title of certifie 29d. Date signed (Month, Daly, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 7600 CARROLL AVENUE TAKOMA PARK, MARYLAND 20912 PADMA CHIRUMAMILLA M.D.31. Date filed (Month, Day, Year) APR 0 4 2011

DHMH 17 Rev 7/2009

State Registrar 32. Registra/s Signa

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygienes For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month Dorsey Hickman Lee Medical March 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death 902 Greenbackville Road Stockton Worcester Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. **Funeral** 8. Date of Birth 9. Birthplace (State or Foreign 230-14-1538 1 🛛 M 2 🗆 F Days Months Min Hours 06/21/1924 Director Maryland 86 Usual Residence of Decedent 28a-f show 10a. State 10b. County r than "natural", or items 23a or 28a-f sho the Medical Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 X No Maryland Worcester Stockton 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 902 Greenbackville Road 21864 USA death 11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. þ 1 Never Married 2 X Married 1 ☐ Yes 2 🎛 No If Yes, Give 72 hours after Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Completed 3 Widowed 4 Divorced white Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) Ith and Mental Hygiene. 27 is marked other than traumatic event, the Me Elementary/Seconday (0-12) College (1-4 or 5+) Bus Driver Public School System Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Department of Health and Menta Important: If item 27 is marked any injury or other three 2 Fred Hickman Bernice 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code, Janice A. Hickman/spouse 902 Greenbackville Rd., Stockton, MD 21864 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 \blacksquare Burial 2 \square Cremation 3 \square Removal from State cemetery, crematory or other place Portersville 4/2011 4 ☐ Donation 5 ☐ Other (Specify) oyeton, MD of Fun Service Licensee 22. Name and Address of Facility Holloway Funeral Home Professional Association Vine St., Pocomoke City, MD 21851 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death etestatie Corcinoma Physician/ Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, Examine if any, leading to immediate cause. Litter Underlying Cause (Disease or iinjury Due to (or as a consequence of) To the Hospital or Attending Physician: The law requires that the death certificate be executed the burial-transit and that initiated events resulting in death) Last Due to (or as a consequence of): attending physician Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: use 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months? 5 Other (specify) Day Pregnant at time of death Month Year 2 No been signed by the should be detached 9 Unknown g Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? Completed by cro 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an ours after death, eral Director: After this certificate has I filled in by the funeral director, page 2 s performed' 1 Yes 2 No Yes 2 No 25. Was case referred to medical Be 26. Place of Death (Check only one) 2 No Hospital Other: 1 🗌 Yes 은 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify) Certificate: 27, Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred Natural 5 Pending injury 1 ☐ Yes 2 ☐ No ☐ Accident ☐ Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined within 24 hours a Medical 🗠 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) rom 1) 14 314 April 1, 2011 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

State

Registrar

PANPITP

31. Date filed (Month, Day, Year)

KLUa.

APR 0 4 2011

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Registrar's Signature

BA 6

East Court Street, Solinbury, mo 21804

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene for State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day 2011 Physician/ March 28, Lawrence Maurice Harper 8:30 AM Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death Frederick Glade Valley Nursing & Rehab Center Walkersville 5. Social Security Number If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign 7. Age (In vrs. last birthday) 8. Date of Birth Funeral 1 **X** M 2 □ F Days Min Feb. 5, 1922 Hours Vrs Maryland 89 Director 577-28-7064 Usual Residence of Deceden 28a-f shov 1 and 2 should be filed within 72 hours after death with the Maryland of Health and Mental Hygiene. fitem 27 is marked other than "natural", or items 23a or 28a-f sho other traumatic event, the Medical Examiner must be notified at. 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 X No Frederick Maryland Frederick 10e, Street and Number 10f. Zip Code 10q. Citizen of What Country? Funeral 7405 Skyline Drive 21702 United States 12. Was Decedent Ever in U.S Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. 1 ☑ Yes 2 ☐ No If Yes, Give ₩WII Year or Dates. ģ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🛣 No Specify: 3 X Widowed 4 Divorced Specify: Completed White 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Telephone Technician Telecommunications Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ၉ Charles Rice Jenny Harper Department of Health and Important: If item 27 is n. any injury or other traums once. 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Larry S. Harper / Son 7405 Skyline Drive, Frederick, MD 21702 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other place)
Resthaven Crematory March 1 Burial 2 X Cremation 3 Removal from State Frederick, Maryland 2011 4 ☐ Donation 5 ☐ Other (Specify) 21. Signatur Funeral rvice Licensee 22. Name and Address of Facility Resthaven Funeral Services, Skkot Cody P.A. 9501 Catoctin Mountain Hwy. Frederick, MD 21701 dee, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, so List only one cause on each line. 23a. Part 1. Enter the dis shock, or heart faile Approximate Interval Between Onset and Death days Immediate Cause (Final disease or condition Physician/ Pneumonia Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, Examine Due to (or as a consequence of): if any, leading to immediate cause. Enter Underlying the burial-transit Dause (Disease or linjury that initiated events and Due to (or as a consequence of): resulting in death) Last physician Physician/Medical Division of Vital Records, P.O. Box 68760 as IF FEMALE: 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months? Month Day Year Pregnant at time of death Unknown g Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? <u>\$</u> Alzheimer's Disease Completed 1 ☐ Yes 2 🖾 No 3 ☐ Probably 4 ☐ Unknown filled in by the funeral director, page 2 should 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy performed? death? 2 🔀 No 2 🗌 No Yes Hospital or Attending Physician: 25. Was case referred to medical Be Other: 1 🗌 Yes 2 🔀 No ည 1 Inpatient 2 ER/Outpatient 3 DOA 4X Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) after death.

Director: After this 27, Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 X Natural 5 Pending 1 🗌 Yes 2 🗌 No Accident Investigation Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) within 24 hours a Medical ☑ Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.
 ☑ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier npleted (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one 29b. Signature at title of certifier D 26516 March 29, 2011

State

31. Date filed (Mont)

Registrar

1475 Taney Ave., Frederick, MD 21702

completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

BARRE

Gilson, M.D.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene, 1 - State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month 20 11 Physician/ 25 PM LeVerna Maude Jackson Medical 4a. Facility Name (if not institution, give street and number) 4b, City, Town, or Location of Death 4c. County of Death **Examiner** Prince George's Doctor's Community Hospital 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs 8. Date of Birth 9. Birthplace (State or Foreign Funeral 1 □ M 2 🛣 F Months Days Hours Min. 06/06/1924 Maryland **Director** 86 <u>212-26-8609</u> Usual Residence of Decedent 28a-f show 10b. County 10d. Inside City Limits 10a. State 10c. City. Town or Location or than "natural", or items 23a or 28a-f sho the Medical Examiner must be notified at Director Oxon Hill 1 🖳 Yes 2 🗀 No Prince George's 10e Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral USA 20745 1008 Marcy Avenue apt.#101 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14 Bace - American Indian Armed Forces? Yes, specify Cuban, Mexican, Puerto Rican, etc. Black, White, etc þ 1 Never Married 2 Married Black If Yes, Give Year or Dates 1 ☐ Yes 2 XNo Specify: Completed 3 ₩ Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life, DO NOT use retired) and Mental Hygiene. is marked other than Elementary/Seconday (0-12) College (1-4 or 5+) Own Home Housewife Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Maude Jones permit. Page 1 and 2 should be Department of Health and Mem Important: If item 27 is marke any injury or other traumatic. William Savoy 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code 1008 Marcy Avenue apt. #101 Oxon Hill, MD 20745 Peggy Y. Jackson/Daughter 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State 1 Burial 2 ☐ Cremation 3 ☐ Removal from State cemetery, crematory or other place, Harmony Memorial Park 04/11/2011 Landover, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Marshall-March Funeral Home Signature of Funeral Service Licensee 4308 Suitland Road Suitland, MD 20746 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Betweer Onset and Death Immediate Cause (Final Physician/ Pneumonia disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, Due to (or as a consequence of): if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Exam that the death certificate be executed Due to (or as a consequence of): resulting in death) Last physician a sthe burial-1 Physician/Medical attending p IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ctopic pregnancy
5 Other (specify) in the past 12 months?

1 Yes 2 No Month Day Year Pregnant at time of death Unknown 9 Unknown þ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ate has been signed bage 2 should be det Completed by Alzheimer's Dementia 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 😾 Unknown 24b. Were autopsy findings available prior to completion of cause of death? Acute Renal Failure 24a. Was an autopsy performed? Yes 2 K 2 🛚 No 1 Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 🖰 No မ 1 Ninpatient 2 ER/Outpatient 3 DDA 28a. Date of injury (Month, Day, Year) 28b. Time of 27. Manner of Death 28c. Injury at Certificate: 28d. Describe how injury occurred Hospital or Attending 24 hours after death. 1 🔀 Natural 5 Pendina 1 Yes 2 No thin 24 hours after death the Funeral Director: A impleted filled in by the fi Accident Suicide Investigation Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Byanniner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check 29b. Signature and title of g 29d. Date signed (Month, Day, Year) 04/03/2011 D43351 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Baltimore, Maryland 21215-0036

Box 68760

P.O.

Records,

Vital

Division of

State

31. Date filed (Month, Registrar

Ikechi Frederick Okwara 12200 Annapolis Road #316 Glenn Dale, MD 20769

State of Maryland / Department of Health and Mental Hygien@ 1 State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month March 2011 4:40 A.M Clifton Jackson Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Cheverly

Vear I If Under 24 Hrs.

Min. Prince George's Hospital Center Prince George's Social Security Number 8. Date of Birth Birthplace (State or Foreign Country) 7. Age (in yrs. **Funeral** Months 1 🔀 M 2 🗆 F 92 Director 578-03-3306 04/26/1918 Aiken. Usual Residence of Decedent or 28a-f show notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director D.C. 1 XYes 2 No Washington 10e. Street and Number 10f. Zip Code ò 10g. Citizen of What Country? ral", or items 23a o Examiner must be Funeral 607 4th St., N.E. U.S.A. 20002 death v 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, 11. Marital Status Black, White, etc. ve 43-'46 þ 1X Yes 2 If Yes, Give Year or Dates. 1 Never Married 2 Married within 72 hours after Baltimore, Maryland 21215-0036 Black 1 ☐ Yes 2 🛂 No Specify: "natural" Completed 3 X Widowed 4 Divorced Specify: al Hygiene. d other than "natura event, the Medical E 16a. Decedent's Usual Occupation 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) 12th Press Foreman/NIH U.S. Government Be e filed 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) permit. Page 1 and 2 should be filed Department of Health and Mental Hy Important: If item 27 is marked oth any injury or other traumatic even one. ဂ္ Lewis Jackson Henrietta Williams 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Vernell P. Fergusson/Niece 906 S.16th Street, Harrisburg, Pennsylvania 17104 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other place) 1 X Burial 2 Cremation 3 Removal from State 04/04/11 4 Donation 5 Other (Specify) Lincoln Cem. Suitland, Maryland 22. Name and Address of Facility Henry S. Washington & Sons Co., Inc. 4925 Burroughs Ave., N.E., Washington, D.C acu. xxll 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Ph_sician/ disease or condition resulting in death) Medical **Examiner** Sequentially list conditions. Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of): requires that the death certificate be executed -tran that initiated events resulting in death) Last Due to (or as a consequence of) attending physician for use as the burial Physician/Medical Box 68760 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 3 Ectopic pregnancy

5 Other (specify) IF FEMALE: 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months? Month Day Year signed by the at the detached for 1 Yes 2 No 9 Unknown 9 Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🗯 Unknown Completed page 2 should 24b. Were autopsy findings available prior to completion of cause of death? To the Hospital or Attending Physician: The law within 24 hours after death.

To the Funeral Director. After this certificate has t completed filled in by the funeral director, page 2 s autopsv performed? Yes 2 No 2 🗌 No ☐ Yes Division of Vital 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital 2 No Other: မ 1 Tyes 4 Nursing Home 5 Residence 6 Other (Specify) 1 🗷 Inpatient 2 🗆 ER/Outpatient 3 🗆 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred 1 Matural injury work?
1 \(\sum \) Yes 2 \(\sum \) No 5 Pending Accident Investigation 6 Could not be 3 ☐ Suicide 4 ☐ Homicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined Medical 🗡 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one HKU OLOG 39c. License number 29b. Signature ar 29d. Date signed (Month, Day, Year) D57926 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Vivek Bahl, M.D. 8116 Good Luck Road, 305, Lanham, Maryland 20706 31. Date filed (Month, Day, Year)

APR 0 5 2011 State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month April 201^{Year} 6:03 **JAMES** FREDERICK KOOGLE Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Frederick Frederick Memorial Hospital Frederick 5. Social Security Number If Under 1 Year If Under 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Maryland Days Hours January 6. Director 220-28-3540 Usual Residence of Decedent 27 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 72 hours after death with the Maryland 10d. Inside City Limits Director Maryland Frederick Walkersville 1 X Yes 2 ☐ No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 8828 Challenge Walk 21793 United States 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, 11. Marital Status Armed Forces?

1 X Yes 2 No Black, White, etc ģ 1 Never Married 2 X Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: ii res, Give Year or Dates 1953–1956 White Completed 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business Industry nd Mental Hygiene. marked other than Elementary/Seconday (0-12) College (1-4 or 5+) 10 Plumber Plumbing Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Conley A. Koogle Margaret E. Unglesbee Page 1 and 2 should tment of Health and N tant: If item 27 is ma jury or other traumal 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <u>8828 Challenge Walk, Walkersville, MD 21793</u> <u>Rita Koogle / Wife</u> 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State April Pate 12. artment of ortant: If it injury or c 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 2011 Jefferson, Maryland Paul's Lutheran Cem. per nit.
Dek artn
Imp ortk
any inju 21. Signature of Funeral Service Lice is Reeney and Bastord PA Funeral Home, 106 East Church St., Frederick, Maryland 21701 23a. Part 1. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between shock, or heart failure. Just only one cause on each line Immediate Cause (Final Onset and Death Obstructi Ph_sician/ Chranic disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions. Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of) Hospital or Attending Physician: The law requires that the death certificate be executed for use as the burial-transi that initiated events resulting in death) Last Due to (or as a consequence of): attending physician Completed by Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 5 Other (specify) Month Day Year Pregnant at time of death signed by the a 4 ☐ Pregnant 9 ☐ Unknown g Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 Ø Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a, Was an within 24 hours after death.

To the Funeral Director: After this certificate has completed filled in by the funeral director, page 2 s autopsy performe 1 ☐ Yes 2 ☐ No 2 N 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes Inpatient 2 ER/Outpatient 3 DOA မ 28c. Injury at work? 1 ☐ Yes 27. Manner of Death Date of injury (Month, Day, Year) 28b. Time of Certificate: 28d. Describe how injury occurred 1 Natural injury 5 Pending Accident 2 🗆 No Investigation 3 Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner. On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 8 MO MD 51610 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 21702 Ta 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene) For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death 1811 PM Physician/ Month Regina Antionette Kennedy Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Prince George's Doctor's Community Hospital Lanham If Under 1 Year If Under 24 Hrs. 8. Date of Birth 7. Age (In yrs. last birthday) g, Birthplace (State or Foreign **Funeral** Min. Days 1 □ M 2 🖾 F Months Hours 12477777985 Washington, DC 578-13-0030 25 Director Usual Residence of Decedent 28a-f shov 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits with the Maryland injury or other traumatic event, the Medical Examiner must be notified 1 Yes 2 No MD Prince George's Landover 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number ö Funeral items 23a 20785 USA 7727 Willow Hill Drive Page 1 and 2 should be filed within 72 hours after death ment of Health and Mental Hygiene. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, 11. Marital Status Armed Forces?

1 Yes 2 No Black, White, etc 'natural", or by 1 X Never Married 2 Married 21215-0036 Black 1 Yes 2 No Specify: If Yes, Give Year or Dates. Completed 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business Industry Elementary/Seconday (0-12) College (1-4 or 5+) and Mental Hygiene. is marked other tha None ĺlth None Be Maryland 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) ည Reginald Hawkins Claudia Thomas 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 sh Department of Health ar Important: If item 27 is any injury or other trau Willow Hill Dr., Landover, MD 20785 <u>Devona Givens/Sister</u> Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place Removal from State □ Cremation 3 □ Removal from State Landover, MD Harmony Memorial Park 04/04/2011 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Marshall-March Funeral Home 21. Signature of Funeral Service Licenses 4308 Suitland Road Suitland, MD 20746 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Priysician/ Hypoxic Respiratory Insufficiency disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Pneumonia Sequentially list conditions, if any cause. Enter Underlying Examine Due to for as a consequence of Cause (Disease or iinjury Hospital or Attending Physician: The law requires that the death certificate be executed Hypotension attending physician and for use as the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Acquired Immune Deficiency Syndrome Division of Vital Records, P.O. Box 68760 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No ☐ Pregnant at time of death☐ Unknown 5 Other (specify) Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4. Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a. Was an cate has page 2 s autopsy performed? certificate Yes 2 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Other: 1 Tes 2 No ၉ 1- Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify) this 28a. Date of injury (Month, Day, Year) n 24 hours after vecum. ne Funeral Director: After th 27. Manner of Death 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred injury 1-Natural 5 Pending work?
1 Yes 2 No 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 29b. Signature and title of certifie 29d. Date signed (Month, Day, Year) MARCH 29, 2011 MDD60925 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 8118 GOOD LUCK ROAD LANHAM MD 20706 FASIKA, MD ELIZABETH 31. Date filed (Month, Day, Year, 32. Registrar's Signature State 2011 Registrar

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 1 Decedent's Name (First Middle, Last) 2. Date of Death Physician/ Month Madelyn Sue Linton 2011 <u> April</u> Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 2481 Wayside Court Frederick Frederick If Under 7. Age (In yrs. last birthday) If Under 24 Hrs. Birthplace (State or Foreign Country) Social Security Number 8. Date of Birth **Funeral** Days Min 73/1935 1 □ M 2 👿 F Hours 75 Yrs. Director 370-38-4168 Indiana Usual Residence of Deceden "natural", or items 23a or 28a-f shovedical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Page 1 and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene. Director 1 🖙 Yes 2 🗌 No MD Frederick Frederick 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? Funeral <u> 2481 Wayside Court</u> 21702 <u>United States</u> 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Never Married 2 Married 1 Yes 2 If Yes, Give Year or Dates. þ 2 **X**No Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify: White Specify: 3 Divorced 4 Divorced Completed Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natun any injury or other traumatic event, the Medical once. 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) College (1-4 or 5+) Elementary/Seconday (0-12) Registered Nurse Health Care 4 Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Elwin McCray Doris Husted 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Bruce Linton / husband <u> 2481 Wayside Ct., Frederick.</u> MD 21702 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) cemetery, crematory or other place) Olivet Cemetery 4/15/2011 Frederick, MD Signature of Funeral Service Licensee 22. Name and Address of Facility Keeney & Basford Funeral Home depeller 106 E. Church St., Frederick, MD 21701 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death · Physician/ disease or condition Adenocarcinoma of Peritoneum vears Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions Examine Due to (or as a consequence of): if any, leading to immediate Cause (Disease or iinjury attending physician and for use as the burial-tran that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical IF FEMALE: be detached for use 23d. Date of delivery 23b. Was decedent pregnant Completed by page 2 should

To the Hospital or Attending Physician: The law requires that the death certificate be executed Division of Vital Records, P.O. Box 68760 To the Funeral Director: After this certific completed filled in by the funeral director, within 24 hours a To the Funeral I

Be မ

Certificate:

Medical

29b. Signature and title of certifier

31. Date filed (Month, I

Menilla

<u>Martha</u>

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

18

1 Yes 2 No 9 Unknown	4 ☐ Pregnant at time of death 5 ☐ Other (specify) 9 ☐ Unknown	Month Day Year				
Part II. Other significant conditions	s contributing to death but not resulting in the underlying cause given in Part I. 23e. [Did tobacco use contribute to the cause of death?				
Hyponatremia,	Bowel obstruction	Yes 2 No 3 Probably 4 Unknown				
		Was an autopsy performed? 24b. Were autopsy findings available prior to completion of cause of death? Yes 2 ∑ No				
25. Was case referred to medical	26. Place of Death (Check only one)					
examiner? 1 Yes 2 No	Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 ☐ Nursing Home 5 🛣 F	e 5 K Residence 6 □ Other (Specify)				
27. Manner of Death 1 Natural 5 Pending 2 Accident Investigat	(Month, Day, Year) injury work? tion M 1 ☐ Yes 2 ☐ No	ibe how injury occurred				
3 Suicide 6 Could no 4 Homicide determine	ed 28e. Place of Injury - At home, farm, street, factory, office 28f. Location 28f. Lo	on (Street and Number or Rural Route Number, r Town, State)				
	hysician: To the best of my knowledge, death occured at the time, date and place, and due to the aminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, d					

3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29c. License number

D 46248

9th St., Frederick, MD 21701

29d. Date signed (Month, Day, Year)

04/11/11

DHMH 17 Rev 7/2009

Registrar

State

300 W.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiens For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ LINDSLEY BUCK LUDY APRIL 2011 5:00 PM Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death 15525 POTOMAC RIVER DRIVE COBB ISLAND CHARLES . Social Security Number **Funeral** 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign 1 M 2 X Days Hours Min 297-09-9353 JUNE Day Year 922 88 OHTO Director Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show amy injury or other traumatic event, the Medical Examiner must be notified once. 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director MD CHARLES 1 ☐ Yes 2 🛣 No COBB ISLAND 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 15525 POTOMAC RIVER DRIVE 20625 U. S. A. 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14 Bace - American Indian Armed Forces Black, White, etc. 1 Never Married 2 Married Completed by 2X No Baltimore, Maryland 21215-0036 1 ☐ Yes XXNo Specify: If Yes, Give 3 XWidowed 4 ☐ Divorced Specify: WHITE Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) ORDAINED MINISTER 5+ UNITED CH.OF CHRIST Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 CHARLES BUCK EMMA SCHUMAKER 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 15525 POTOMAC RIVER DR. COBB ISLAND, MD20625 BEVERLIE LUDY/DAUGHTER 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State APRIT metery, crematory or other place, 1 Burial 2X Cremation 3 Removal from State METRO . CREMATORY 4 ☐ Donation 5 ☐ Other (Specify) 12,2011 ALEXANDRIA, VA 21. Signature of Funeral Service Licer 22. Name and Address of Facility RAYMOND FUNL. SERVICE, P.A. cry M00641 5635 WASHINGTON AVE., LA PLATA, MD 20646 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Immediate Cause (Final Onset and Death Physician/ DENTENTI disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner ONGEST 24E HEDRT MUINT IN Sequentially list conditions, if any, leading to immediate Examine Due to (or as a consequence of) cause Enter Underlying Cause (Disease or iinjury that initiated events that the death certificate be executed and Due to (or as a consequence of): resulting in death) Last attending physiciar Physician/Medical Box 68760 IF FEMALE: 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?

1 Yes 2 No Day Pregnant at time of death Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Division of Vital Records, Hospital or Attending Physician: The law requires 24 hours after death. 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autonsy After this certificate 1 ☐ Yes 2 ☐ No _Yes 2 No 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital 1 ☐ Yes 2 🔀 No Other: Certificate: To 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Natural 5 Pending iniury work?
1 Yes 2 No Director: / Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, completed filled in by 4 Homicide determined City or Town, State) within 24 hours a Medical 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Number Frantiener: To the basis of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check 29d. Date signed (Month, Day, Year) 2011 R148876 世ルッ 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) LAGRANCE 115 B AVE PASTERSON LAPHATA MICHAL 20646 MARYLAND 31. Date filed (Month, Day, 32. Registyar's Signature

DHMH 17 Rev 7/2009

State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Mertine 0. 2011 3:15 P.M March 31 Medical 4a. Facility Name (if not institution, give street and number) Examiner 4c. County of Death Laurel Morningside House Prince George's 5. Social Security Number If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 8. Date of Birth (Month, Day, Dec. 28 7. Age (In yrs. last birthday, 9. Birthplace (State or Foreign **Funeral** Months 1 M 2 XF D.C. 79 Director 578-46-3137 Usual Residence of Decedent 27 Is marked other than "natural", or items 23a or 28a-f shov traumatic event, the Medical Examiner must be notified at Page 1 and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene.
ant: If item 27 is marked other than "natural", or items 23a or 28a-f sho 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director Laurel Prince George's MD 1 X Yes 2 No 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? Completed by Funeral 7700 Cherry Lane Laurel U.S. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian, Armed Forces?
1 ☐ Yes 2 🔀 No Black, White, etc 1 X Never Married 2 Married Baltimore, Maryland 21215-0036 African American 1 ☐ Yes 2 X No Specify: If Yes, Give 3 Divorced 4 Divorced Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Accounting Technician Coverment Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Lenwood Lewis Callie Harris 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Juanita Doswell-Niece 712 7th Street, N.E., Washington, D.C. 20002 injury or other 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Department of H Important: If ite any injury or ot 1 X Burial 2 Cremation 3 Removal from State 4-12-2011 Landover, MD 4 ☐ Donation 5 ☐ Other (Specify) Harmony Mem. Pk. permit. 21. Signature of Juneral Service Licensee 22. Name and Address of Facility 20018 Bornette & Assoc. Funeral Home 2504 28th St., N.E., WDC 2 (a. Part 1. Enter the dise of or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failur. List only on the use on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlyin, Cause (Disease or iinjury Examiner Due to (or as a consequence of): sician and burial-transit that initiated events Due to (or as a consequence of) resulting in death) Last Physician/Medical e Hospital or Attending Physician: The law requires that the death certificate be en 24 hours after death.
Per hours after death.
Per Jeneral Director: After this certificate has been signed by the attending physicia Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ctopic pregnancy
5 Other (specify) in the past 12 months?
1 Yes 2 No Month Day Year Pregnant at time of death 9 Unknown 9 Unknown Division of Vital Records, P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🖟 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 1 ☐ Yes 2 ☐ No Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner?
1 ☐ Yes 2 X No Other: 4 Nursing Home 5 Residence 6 X Other (Specify) မ 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of injury (Month, Day, Year) Certificate: 27. Manner of Death 28b. Time of 28c. Injury at work? 1 ☐ Yes 2 ☐ No 28d. Describe how injury occurred 1 Natural 5 Pending ☐ Accident☐ Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 29a, Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. completed 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check within 2 To the only one 29b. Signature and title of certifier Sheradn 2011 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Gallant FUX 20715 # 210 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar

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30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

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32. Registrar's Signature

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April 09, 2011

Health system cumberland, mo 21503

12500 WILLOWBROOK KO

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ OFFAINE Kuth Middleton Medical 4a. Facility Name (if not institution, give street and number) County of Death 4b. City, Town, or Location of Death **Examiner** Silver Spring MontGomery rass HOSPITAL 9. Birthplace (State or Foreign If Under 1 Year If Under 24 Hrs. 8. Date of Birth 7. Age (In yrs. last birthday) **Funeral** Min 78-48-1089 1 □ M 2 🛣 F Director show permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once. 10b. County 10a. State 10c. City, Town or Location 10d. Inside City Limits Director Emple 1X Yes 2 No MD De. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 8270 amwor 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11 Marital Status Black, White, etc. Completed by 1 Never Married 2 Married 1 Yes 2 No Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify. Specify: BLOCK 3 Widowed 4 Divorced Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Public Schools Handler 10TH 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) anci 19a. Informant's Name/Relationship (Type, Print) 19b. Malling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) amworth Court, Temple Hills, MI).20748 . Middleton/spouse 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State WasHington, DC live-4-01-11 4 ☐ Donation 5 ☐ Other (Specify) 420 H ST. NE. WOSH, D.C., Z0002 Signature of Funeral Service Licensee Name and Address of Facility Henry Funeral Home Part T. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician/ OVA Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of): Cause (Disease or impury or Attending Physician: The law requires that the death certificate be executed use as the burial-trans that initiated events resulting in death) Last and Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregna 5 Other (specify) in the past 12 months?

1 Yes 2 No Ectopic pregnancy Month Day Year Pregnant at time of death 9 🔲 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 2 No 1 Yes 25. Was case referred to medical Certificate: To Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Tes 2 X No 1 Nnpatient 2 ER/Outpatient 3 DOA this e Hospital or Au...
24 hours after death.
—al Director. After th?
—... the funer 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred X Natural 5 \square Pending 1 Yes 2 No Investigation Accident Suicide Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined To the Hospital within 24 hours a To the Funeral C Medical 29a Certifier 1 🔀 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. completed Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 🗆 Certifying Nurse Practioner. To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) ss of person who completed cause of death (Item 23a) (Type, Print) 30. Name and addr Glen Rd. 500 FOVEST Nioke MIGHT 31. Date filed (Mon State Registrar

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registra Amend#2.PerPhys.PGC4-7-11cr Certificate of Death Reg. No 2. Date of Death 29 Day 1. Decedent's Name (First, Middle, Last) Physician/ Month MARCH MARCELLE EDITH D. 28 2011 10:05 P M Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner MONTGOMERY SILVER SPRING 1412 MIMOSA LANE If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) Social Security Number 6. Sex 7. Age (In vrs. last birthday, 8. Date of Birth **Funeral** Hours (Month, Day,)
JUNE 14 1 M 2 X F Director 075-18-1379 PA. 85 Usual Residence of Decedent 28a-f show 10a. State 10b. County 10c. City, Town or Location 10d, Inside City Limits traumatic event, the Medical Examiner must be notified at Director MD MONTGOMERY SILVER SPRING Yes 2 No 23a or 2 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Completed by Funeral 20904 USA 1412 MIMOSA LANE Page 1 and 2 should be filed within 72 hours after death 12. Was Decedent Ever in U.S Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status 0 1 Never Married 2X Married 1 Yes 2X No Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify: BLACK 3 🗆 Widowed 4 🗆 Divorced Specify: "natural" Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) and Mental Hygiene. is marked other than Elementary/Seconday (0-12) College (1-4 or 5+) 12TH PRIVATE CLERK Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ FLOYD SCOTT RUTH ANDERSON 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1412 MOMOSA LANE SILVER SPRING, MARYLAND 20904 item 27 CLARENCE A MARCELLE/HUSBAND injury or other 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date permit. Page 1 a
Department of H
Important: If ite
any injury or otl 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) MD VETERANS CEMETERY 4/4/2011 CHELTENHAM, MARYLAND JENKINS FUNERAL HOME, INC. 22. Name and Address of Facility J.B.21. Signature of Funeral Service Licenses 7474 LANDOVER ROAD HYATTSVILLE, MARYLAND 20785 ot enter the mode of dying, such as cardiac or respiratory arrest, 23a. Part 1. Enter the disease, or complications that caused the death. shock, or heart failure. List only one cause on each line Immediate Cause (Final Onset and Death Physician/ CEREBRAL VASCULAR ACCIDENT disease or condition Medical resulting in death) Due to (or as a consequence of) **Examiner** ATERIAL FIBRILLATION Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to for as a consequence of: Cause (Disease or iinjury that initiated events resulting in death) Last HYPERTENSION Due to (or as a consequence of) Physician/Medical To the Hospital or Attending Physician: The law requires that the death certificate be Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ 1 ☐ Live Birth 2 ☐ Fetal deat 4 ☐ Pregnant at time of death 9 ☐ Unknown in the past 12 months? Month Day Year 9 Unknown Division of Vital Records, P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ DIABETES MELLITUS TYPE 2 1 ☐ Yes 2 X No 3 ☐ Probably 4 ☐ Unknown Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of autopsy performed? Yes 2 X No page death? 1 ☐ Yes 2 🛛 No 25. Was case referred to medical Be 26. Place of Death (Check only one) 1 ☐ Yes 2 🔀 No Other: မ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 X Residence 6 Other (Specify) Certificate: 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred s after dea... ral Director: Aftr 1 X Natural 5 Pending 1 ☐ Yes 2 ☐ No Accident Investigation Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 1 🖾 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.
2 🔲 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier pleted (Check

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only one)

31. Date filed (Month, Day

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29b. Signature and title of certifier

SORANA HILA M.D

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30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Registra

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated

3941 FERRARA DRIVE WHEATON, MARYLAND 20906

29c. License number

D70217

29d. Date signed (Month, Day, Year) APRIL 1, 2011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registra Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ ARDIANTI MARAFIE UNARTI 01 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death GENERAL HOSPITAL MONTGOMERY MONTGOMERY DLNE 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Months Days Hours 50 960 TNDONESIA Director Usual Residence of Decedent show Trint. Page 1 and 2 should be filed within 72 hours after death with the Maryland partment of Health and Mental Hygiene. Increant: If item 27 is marked other than "natural", or items 23a or 28a-f show injury or other traumatic event the Maryland. 10a. State 10c. City, Town or Location 10d. Inside City Limits **Funeral Director** 1X Yes 2 No ROCKVILLE MONTGOMER 10e. Street and Number 10g. Citizen of What Country? 4900 M 208 INDONE SIA 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian Black, White, etc. Completed by 1 Never Married 2 Married 1 ☐ Yes 2 X No If Yes, Give Maryland 21215-0036 1 Yes 2 No Specify: ASIAN 3 Widowed 4 Divorced Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) RESTAURANT WAITRESS 12 Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 KOENRAHAROJO SOEDOMO SOEBAGJO 19a. Informant's Name/Relationship (Type, Print) SISTER 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code, ARYANA HENDRAWAN EESBURG 19111 CHARTIER Baltimore, 20b. Place of Disposition (Name of 20a. Method of Disposition BERY 4/02/11 1 KBurial 2 ☐ Cremation 3 ☐ Removal from State ADELPHI, MD. 4 Donation 5 Other (Specify) permit.
De artm
Importa
any inju 22. Name and Address of Facility ADEN MUSLIM FUNERAL SER. 21. Signature of Funeral Service Licensee 1242 EASY STREET WOODBRIDGE VA. 22191 23a. Part 1. Enter the disease, a complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line Immediate Cause (Final Physician/ alu disease or condition resulting in death) Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Certificate: To Be Completed by Physician/Medical Examiner Due to (or as a consequent of) and Due to (or as a consequence of): resulting in death) Last attending physician the Hospital or Attending Physician: The law requires that the death certificate be Box 68760 IF FEMALE yes, outcome of pregnancy

Live Birth 2 Fetal death 3 Ectopic pregnancy

Pregnant at time of death 5 Other (specify) 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months? Month 1 Yes 2 No 9 Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the use of death? Division of Vital Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 2 1 Tyes 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: ✓ No 1 Inpatient 2 R/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) within 24 hours after death.

To the Funeral Director: After this completed filled in by the funeral director. 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Natural Accident Suicide injury 5 Pending 1 ☐ Yes 2 ☐ No Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29d Date signed (Month, Day, Year) who completed cause of death (Item 23a) (Type, Print) MGH 1801 State

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Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Closker Month 112 AM 2011 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Maricamie CHONHITEM Musur. TAKOMA MARK If Under 1 Year | If Under 24 Hrs. . Social Security Number 9. Birthplace (State or Foreign 7. Age (In vrs. last birthdav) 8. Date of Birth **Funeral** 1 🗆 M 2 🖾 F Days Hours Min. Year Country)
Wilson **Director** 64 March 215-44-4510 NC Usual Residence of Decedent show 10a. State 10c. City, Town or Location Page 1 and 2 should be filed within 72 hours after death with the Maryland 10b. County 10d. Inside City Limits Director other traumatic event, the Medical Examiner must be notified 28a-f 1 X Yes 2 No Prince George's Mount Rainier ò 10e Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral items 23a 20712 4025 34th Street USA 11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14, Race - American Indian, Black, White, etc. ō ģ 1 Never Married 2 X Married Yes 2 No Yes, Give Baltimore, Maryland 21215-0036 1 Yes 2 No Specify. Specify: Completed 3 Divorced 4 Divorced White Year or Dates. 15. Decedent's Education 16a Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life, DO NOT use retired) d Mental Hygiene. marked other than Elementary/Seconday (0-12) College (1-4 or 5+) 11 General Manager Contracting Company Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) James Thomas Wheeler Juanita Fields permit. Page 1 and 2 should Department of Health and M Important: If item 27 is man any injury or other traumat 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Edward J. McCloskey, Jr./Husband 4025 34th Street, Mount Rainier, MD 20712 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 1 ☐ Burial 2 🖾 Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Metropolitan Crematory 4/6/2011 Alexandria, Virginia Signature of Funeral Service Licensee 22. Name and Address of Facility 4739 Baltimore Avenue Gasch's Funeral Home, P.A. Hyattsville, MD 20781 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line Immediate Cause (Final Ph sician/ ncerave disease or condition resulting in death) Medical Due to (or as a consequence of **Examiner** Sequentially list conditions, if any, reading to immediate cause. Enter Underlying Examine Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or injury that initiated events the burial-trans Due to (or as a consequence of resulting in death) Last Physician/Medical Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months? Month Day Year Pregnant at time of death Unknown as been signed by the 2 should be detached g 🗌 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 2 No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a. Was an autopsy Yes Division of Vital 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital Other: ၉ 1 Inpatient 2 🕒 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 28c. Injury at 28d. Describe how injury occurred 1 Natural injury 5 Pending work? fter death, 2 🗌 No ☐ Accident ☐ Suicide 2 Investigation 6 Could not be within 24 hours frer de To the Funeral Directo completed filled in by ti 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29c. License number 29d. Date signed (Month, Day, Year) 3542 04-02-2011 ess of person who completed cause of death (Item 23a) (Type, Print) 7600 Canul 31. Date filed (Month, Day, 32. Registrar State

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene. 1 - State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ March 30,2011 CHRISTIAN ALEXANDER MEREDITH 7:09 a M Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Prince Georges Cheverly Prince George Hospital Social Security Number If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday, 8. Date of Birth **Funeral** Days 1 XM 2 D F Months Min. Hours 12-24× 133 Bumpass, VA Director 231-46-9253 73 Usual Residence of Decedent 28a-f shov 10b. County 10a State 10c. City, Town or Location 10d. Inside City Limits **Funeral Director** notified 1 🙀 Yes 2 🗌 No Capital Heights Maryland Prince Georges 10e. Street and Numbe 10g. Citizen of What Country? must be 23a 20743 702 - 60th Avenue AZU 11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. 0 ģ 1 Never Married 2 Married 1 ☐ Yes 2 XNo 1 Yes 2 XNo Specify: "natural" Completed 3 Widowed 4 Divorced Black Year or Dates Medical 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) Il Hygiene. College (1-4 or 5+) Elementary/Seconday (0-12) the Construction aborer Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) should be file h and Mental H 7 is marked o ပ Betty Davis Tucker Meredith traumatic 19a. Informant's Name/Relationship (Type, Print) Jet, 1 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 20744 4301 Bishopmill Drive, Upper Marlboro, MD Crystal Briscoe / Daughter 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State Burial 2 ☐ Cremation 3 ☐ Removal from State ☐ Donation 5 ☐ Other (Specify) Ft. Lincoln Cemetery 04-06-11 Brentwood, MD 21. Signature of Funeral Service 22. Name and Address of Facility Strickland Funeral Services, P.A. 6500 Allentown Rd. Camp Springs, MD and 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line Immediate Cause (Final Physician/ FATAL disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions, Dian to for as a consequence of cause. Enter Underlying Cause (Disease or iinjury that initiated events resulting in death) Last Due to (or as a consequence of): physician a sthe burial-Physician/Medical attending pl IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No Month 5 Other (specify) Day Year Pregnant at time of death ed by the a 9 Unknown Unknown signed by t d be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an Jas page performed? Yes 2 No certificate 1 Yes 2 No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 2 No 1 Tes ပ္ 1 ☐ Inpatient 2 X ER/Outpatient 3 ☐ DOA this (4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) To the Hospital or Attending Pr within 24 hours after death. To the Funeral Director; After th completed filled in by the funeral 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at Natural injury 5 Pending work? 2 🗆 No Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) Homicide determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 🗆 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifier 2011 ho completed cause of death (Item 23a) (Type, Print) Name and address of person

Registrar

31, Date filed (Month, Day

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3altimore, Maryland 21215-0036

Box 68760

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Division of Vital

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117	Funeral		Social Security Number 6	. Sex 7	Age (In yrs.		If Under 1 Year Months Days	If Under 24 H Hours Mi	n. (Month, Da	ıy, Year)	9. Birthplace Country)	e (State or Foreign		
	Director		578-22-0247 Usual Residence of Decedent		90	Yrs.			02/28/1	1921	Washin	gton, DC	_	
	land		10a. State 10b. County		10c. City	y, Town or Lo	cation				10d.	Inside City Limits	_	
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	ems er mu	Funeral	11. Marital Status	12. Was Decede Armed Force	s?	S. 13.	Was Decedent of Hi If Yes, specify Cuba	spanic Origin? n, Mexican, Pu	(Specify Yes or No erto Rican, etc.)	14. Race Blac	e - American I k, White, etc.			
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ana	e filed within 7 al Hygiene. I other than "n vent, the Medi	BeC	17. Father's Name (First, Middle, La					18. Mother's N	lame (First, Middle	, Maiden Surnam	ie)		_	
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Mar)	2 sho and I is ma		19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State									ide)		
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Баппто	it. Pa rtmer rtant: njury		4 Donation 5 □ Other (Specify) Lincoln Memorial 04/08/2011 Suit1a 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Marshall—March 1											
מ	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Deparament of Health and Mental Hygiene. Important: If them 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.		21. Signature of Funeral Service Liv	1000011	1/	I	308 Suitl					nome		
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Sion	nding th. : Afte e fune	tion	27. Manner of Death 28a. Date of Injury 28b. Time of 1 Natural 5 Pending 28a. Date of Injury 28b. Time of 1 Natural 5 Pending 28c. Injury at 28c. Injury at 28d. Describe how injury occurred 38d. Describe how injury occurred											
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5	tal or s afte al Dir ed in	Certification:	4 Homicide building, etc. (Specify) City or Town, State)											
	To the Hospital or Attending Physician: The law within 24 hours after death. To the Funeral Director: After this certificate has completely filled in by the funeral director, page 2 secondly and the funeral director, page 2 second filled in by the funeral director.		(Check only 2 Medical E	Physician: To the be xaminer: On the basi	s of examina									
	thin 2 the orthographic	Medical	one) 29b. Signature and title of certifier	and manner	stated.		29c. License	e number		29d. Date signe	ed (Month, Da	y, Year)	-	
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	Registr	ar	APR 0 5 2011	server be	" T"									

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** March 2011 5:30pMichael Joseph Menze /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Kline Hospice Frederick Mt. Airy 8. Date of Birth (Month, Day, Year) If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 6 Sev 7. Age (In yrs. last birthday) **Funeral** Days Months Hours 1 1 x M 2 □ F Director 212-64-4124 18, 1953 Washington D.C. Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Event. 10c. City, Town or Location 10d. Inside City Limits 10b. County 1 TrYes 2 □ No Director Maryland Carrol1 Mt. Airy 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code by Funeral 7822 East Hill Drive 21771 United States 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ∐Yes 2 XNo If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 🔀 No Specify. Specify: 3 ☐ Widowed 4 🗓 Divorced White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 12 Carpenter Carpentry 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be 2 Henry Menze Nancy Allison 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Monica Menze/ Daughter 7822 East Hill Drive, Mt. Airy, Maryland 2177120a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 □ Donation 5 □ Other (Specify) Stauffer Crematory Inc. 3/30/2011 Frederick, Maryland. 21. Signatur of Funeral Service 22. Name and Address of Facility
Stauffer Funeral Homes P. A.
1621 Opossumtown Pike, Frederick, Maryland 21702 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one gause on each line. Approximate Interval Between Onset and Death mmediate Cause (Final Lung Cauce **Physician** Metastatic 4EAKS disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine law requires that the death certificate be executed attending physician and for use as the burial-tran Due to (or as a consequence of) P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 🗆 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year 5 ☐ Other (specify) signed by the a Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobaceo use contribute to the cause of death? Division of Vital Records, þ 1 Nes 2 No 3 Probably 4 Unknown certificate has been si rector, page 2 should I Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy Physician: The performed 1 ☐ Yes 2 ☐ No 1 ☐ Yes 2 No 25. Was case referred medical examiner? funeral director, 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 DOther (Specify) House 2 No 1 ☐ Yes 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To After this 28a. Date of Injury (Month, Day, Year) 27. Many of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred To the Hospital or Attending I within 24 hours after death. To the Funeral Director: After 5 ☐ Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No 2 Accident completely filled in by the 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 29a. Certifier 1 🖫 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical (Check only 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

State Registrar

29b. Signature and title of certifier

Year)

31. Date filed (Monti

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Fukan Hudhud, MD 46B Thomas Johnson Wive, Ste 20: Frederick, MD

32. Registrar's Signature

29d. Date signed (Month, Day, Year)

4 1866 March 31, 2011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ NAHAR GUM SHAMSUN 0 2011 10:54AM Medical 4a. Facility Name (if not institution, give street and number 4b. City, Town, or Location of Death 4c. County of Death Examiner 20807 SHAMROCK GLEN CIRCLE GERMAN TOWN MONTGOMERY Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 □ M 2 😿 F Days Hours Min. BANGLADESH **Director** Usual Residence of Decedent 28a-f show 10a, State 10b. County 10c. City, Town or Location iral", or items 23a or 28a-f sho Examiner must be notified at 10d. Inside City Limits Director GERMANTOWN 1 Yes 2 □ No MD MONTGOMERY 10e. Street and Number 10g. Citizen of What Country? Funeral 20874 20807 SHAMROCK GLEN CIR. BANGLADESH · death \ 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. by 1 Never Married 2 Married Yes 2 No Maryland 21215-0036 permit. Page 1 and 2 should be filed within 72 hours aft Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", any injury or other traumatic event, the Medical Exar If Yes, Give Year or Dates. 1 ☐ Yes 2 XNo Specify: Specify: ASIAN Completed 3 Widowed 4 ☐ Divorced 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) 2 should be filed within 72 th and Mental Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) HOME HomE MAKER OWN Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ၉ AHMED NURJAHAN BEGUM SADARUDDIN 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code MD 2C 💎 🕻 19a. Informant's Name/Relationship (Type, Print) ALIMED DAUGHTER 20807 SHAMROCK GLEN CIRCLE GERMANTOWN ZEENAT Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State 4/03/2011 FREDERICK MD. 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Ligensee 22. Name and Address of Facility ADEN MUSLIM FUNERAL SER. WOODBRIDGE 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line ment and Death Immediate Cause (Final Physician/ NEOPLASM INVOLVING MALIGNANT disease or condition resulting in death) Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions Examiner in any, reading to immediate cause. Enter Underlying Cause (Disease or linjury Due to (of as a consequence of) and I-transit Hospital or Attending Physician; The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of) physician a s the burial-t Physician/Medical Box 68760 attending ph IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) in the past 12 months? Dav Pregnant at time of death 1 Yes 2 1 9 Unknown Hinknown P.O. is been signed by to should be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Records, 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a, Was an autopsy performed? has page certificate 1 Yes 2 No Division of Vital Be 25. Was case referred to medical funeral director, 26. Place of Death (Check only one) Hospital: 2 No Other: ၉ 1 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) this 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at work? 1 ☐ Yes 2 ☐ No 28d. Describe how injury occurred 5 Pending injury after death.

Director: Aft
in by the fur M Accident Investigation 3 Suicide 4 Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined within 24 hours after

To the Funeral Direct

completed filled in b Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) goseph M. D32407 APRIL 02

State Registrar 9707 MEDICAL CTR. DR. ROCKVILLE MD. 20850

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

JOSEPH M. HAGGERTY MD

APR 0 4

Please Troe or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiens. Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Medical Examiner Name (if not institution, give street and number, 4b. City, Town, or Location of Death inty of Death Andover 5 if Under 1 Year If Under 24 Hrs. Age (In vrs. last birthday 8. Date of Birth (Month, Day, **Funeral** 9. Birthplace (State or Foreign Days Months Hours Min Director Usual Residence of Decedent or 28a-f show 2 should be filed within 72 hours after death with the Maryland th and Mental Hygiene.
27 is marked other than "natural", or items 23a or 28a-f sho item 27 is marked other than "natural", or items 23a or 28a-f sho other traumatic event, the Medical Examiner must be notified at State 10b. County 10c, City, Town or Location 10d. Inside City Limits Director 411670 1 🗌 Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral NITECT 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1. Marital Status Was Decedent Ever in U.S. Armed Forces? 1

Yes 2 □ No If Yes, Give Year or Dates. 1988 - 1992 14. Race - American Indian, Black, White, etc. ò 1 X Never Married 2 Married Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: Black 3 - Widowed 4 - Divorced Completed Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မှ 19a. Informant's Name/Relationship (Type, Print) Department of Health ar Important: If item 27 is any injury or other trainingnee. 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location -1 🔀 Burial 2 🗆 Cremation 3 🗆 Removal from State 4 Donation 5 Other (Specify) Funeral Service License ST. NE. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Physician/ disease or condition resulting in death) Medical Examiner Se grientially list conditions Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Hospital or Attending Physician: The law requires that the death certificate be executed as the burial-transit and that initiated events resulting in death) Last physician Physician/Medical Records, P.O. Box 68760 signed by the attending IF FEMALE: nse yes, outcome of pregnancy

Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No ģ Month Pregnant at time of death Day 5 Other (specify) 1 Yes 2 L 9 Unknown should be detached Part II. Othe cant conditions con libuting to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Certificate: To Be Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an this certificate has page 2 autopsy performed? Yes 2 No 1 Yes **Division of Vital** 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: Inpatient 2 ER/Outpatient 3 E 4 Nursing Home 5 Residence 6 Other (Specify, 27. Man fer of ath 28a Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work?
1 ☐ Yes 2 ☐ No within 24 hours after death.

To the Funeral Director: After of the funeral of the funeral completed filled in by the funeral completed filled 28d. Describe how injury occurred injury Natural 5 Pending Accident Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined To the Hospital within 24 hours a To the Funeral D Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29d. Date signed (Month Day, Year) ause of death (Item 23a) (Type, Print) HOSDHA Date filed (Month) State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Apr 7 Physician/ 2011 9:40 AM Pase Dorothy Elizabeth Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Allegany 13210 Brice Hollow Road Cumberland 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Country) MD 1 □ M 2 □ F Months Hours Min May 29 Director 215-16-4801 88 Usual Residence of Decedent 28a-f show 10a. State 10c. City, Town or Location 10d. Inside City Limits notified at Director Cumberland MD Allegany 1 XYes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ò er than "natural", or items 23a or the Medical Examiner must be Funeral 21502 13210 Brice Hollow Road USA Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14 Bace - American Indian Armed Forces' ☐ Yes 2 ☐ No þ 1 Never Married 2 Married Maryland 21215-0036 1 Yes 2 No Specify: If Yes, Give 3 Widowed 4 Divorced white Completed Year or Dates. 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) and Mental Hygiene. is marked other than Elementary/Seconday (0-12) <u>laborer</u> Celanese Corp Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Carrie (Moore) Jones permit. Page 1 and 2 should be Department of Health and Menl Important; If item 27 is marke any injury or other traumatic e John Jack Jones other traumatic 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code MD 21560 PO Box 72 Joanna Harrison Spring Gap daughter Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other place)
Restlawn Memorial Gardens 1 X Burial 2 Cremation 3 Removal from State 4/9/201 MD LaVale 4 Donation 5 Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility eral Home, PA 108 Virginia Avenue: Cumberland, MD 21502 23a. Part Y. Ent ir the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shork, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ MU disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of) Exami To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director, After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit Cause (Disease or linjury that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 D Ectopic pregnancy in the past 12 months?

1 Yes 2 No Month Year Day Pregnant at time of death 5 Other (specify) g Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an performed Yes 2 1 Yes 2 No 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 1 Yes 2 XNO 4 ☐ Nursing Home 5 NResidence 6 ☐ Other (Specify) ျပ 1 Inpatient 2 I ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Certificate: 1X Natural 5 Pending work? 1 ☐ Yes 2 ☐ No 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certific n who completed cause of death (Item 23a) (Type, Print) ZAMANM 32. Aggistrar's Signature State

900

△ DHMH 17 Rev 7/2009

Registrar

11-02398 Enrico Pagliaro

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

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Baltimore, MD 21215-0036 permit. Pages I and 2 should be filted within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Inportant: If Item 72 is marked other than "natural", or items 23s or 28s-fshow injury or other traumatic event, the Medical Examiner must be notified at once.	Funeral	11. Marital Status		12.		cedent Ever in	U.S.		ecedent of H)-	14. Race - White	- Americ	an India	ın, Black,
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Baltimore, lemit. Pages I and Department of Heal Important: If item njury or other tra	H	4 Donation 5 21. Signature of Fu				per DV	emat R	ion C	e and Addre	ss of F		11		_	WT IMT	ngti	on. DE	Delawar 19803
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Division of Vital Records, P.O. staff or Attending Physician: The law requires that the safe death. **I Director** After this certificate has been signed by led in by the funeral director, page 2 should be detach.	ᇷ	25. Was case referr examiner?	red to medica	Hospi	tal: . m .		7				Death (Chec					3		
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10		 Name and address Zabiullah Ali 				se of peath (Ite	,	1 Penn S	Street, Ba	ltimo	re, MD 2	21201						
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygienes State
Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) Month 2. Date of Death 3. Time of Death Physician/ pril 9:24 M Pear1 Eva Rotz Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Meritus Medical Center Hagerstown Washington 5. Social Security Number If Under 1 Year 7. Age (In vrs. last birthday) If Under 24 Hrs. 8. Date of Birth (Month, Day, Ye 10 24 1 **Funeral** 9. Birthplace (State or Foreign Days Min. Months Director 186-30-5932 88 1922 Waynesboro, Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "hours" any injury or other than "hours". ed other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at 10a State 10b. County 10c. City, Town or Location Director 10d. Inside City Limits WV Berkeley Falling Waters 1 🗌 Yes 2 🔀 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 852 Broad Lane 25419 11 Marital Status 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Forces? Black, White, etc. ģ 1 Never Married 2 X Married If Yes, Give Year or Dates 1 ☐ Yes 2 X No Specify: white Completed 3 Widowed 4 Divorced Specify 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) 10 homemaker own home Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Ralph F. Hoffman Edna G. Biser 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 9729 Garis Shop Rd. Jessica M. Rotz/granddaughter Hagerstown, MD 20a. Method of Disposition
1 ☑ Burial 2 ☐ Cremation 3 ☒ Removal from State 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other place) 4 ☐ Donation 5 ☐ Other (Specify) Antietam Cemetery April 13, 2011 Waynesboro, PA 21. Signature of Funda Service Licenses 22. Name and Address of Facility Grove-Bowersox Funeral Home, Inc. 50 S. Broad St. Waynesboro ,PA 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ AAA disease or condition ofured Medical resulting in death) Due to (or as a consequence of): Examiner 30 min Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine Due to (or as a consequence of): Hospital or Attending Physician: The law requires that the death certificate be executed been signed by the attending physician and should be detached for use as the burial-tran Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months?

1 Yes 2 No 4 Pregnant at time of death 9 Unknown Day Year 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Completed 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 autopsy certificate 1 Yes 2 No 25. Was case referred to medical funeral director, Be 26. Place of Death (Check only one) examiner?
1 Yes 2 No Other 2 1 Inpatient 2 ER/Outpatient 3 IDOA 4 Nursing Home 5 Residence 6 Other (Specify) 24 hours after death. Funeral Director: After this 27. Manner of Death 1 Natural Certificate: 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 5 Pending 1 Yes 2 No Investigation Could not be Accident 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f, Location (Street and Number or Rural Route Number 4 Homicide determined City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one) 29b. Signature and ti e of certifier 29d. Date signed (Month, Day, Year) R06412 Ceise CKNF 시-11-11

DHMH 17 Rev 7/2009

State Registrar 31. Date filed (Month

11110 medical Campus Rd. Hagerstown

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

egistrar's Signatu

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Year RINGOL 400 0 011 Medical 4a. Facility Name (f not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death HOSPITAL CENTER CARROLL WESTMINSTER 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 8. Date of Birth Nov 14, 1929 6. Sex 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** 470-26-6879 1 □ M 2 1 F Days Min. Country) Minnesota **Director** Usual Residence of Decedent ral", or items 23a or 28a-f show Examiner must be notified at 10b. County 10a. State 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 No Maryland Carroll Mt. Airy 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 7705 Pleasant Ridge Drive 21771 United States Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian Armed Forces?
1 ☐ Yes 2 ☒ No If Yes, Give Black, White, etc. by 1 Never Married 2 Married Specify: White 1 Yes 2 No Specify: and Mental Hygiene. Completed 3 🛛 Widowed 4 🗌 Divorced Year or Dates perrit. Page 1 and 2 should be filed within 72 hour De; artment of Health and Mental Hygiene. Imp ortant: If item 27 is marked other than "naturany injury or other traumatic event, the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15 Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Administrative Assistant Pharmaceutical Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Richard Gibbons Marion Hennesey 19a. Informant's Name/Relationship (Type, Print) 19b. Malling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Dave Ringold / son 208 Troon Circle, Mt. Airy, Maryland 21771 20a. Method of Disposition 20b, Place of Disposition (Name of 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State cemetery, crematory or other place) 4 ☐ Donation 5 ☐ Other (Specify) Stauffer Crematory Inc.3/31/2011 Frederick, Maryland. 21. Signature of Funeral Service License 22 Name and Address of Facility Stauffer Funeral Homes 1621 Opossumtown Pike, P. A. Frederick, Maryland 21702 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one have on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ METHICILLIN RESISTANT STAPH AUREUS disease or condition day Medical resulting in death) Due to (or as a consequence of) **Examiner** INFECTION Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of) attending physician and for use as the burial-transit The law requires that the death certificate be executed SACRAL DECUBITU that initiated events Due to (or as a consequence of) resulting in death) Last Physician/Medical 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 3 Ectopic pregnancy

5 Other (specify) IF FEMALE: 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months? 1 ☐ Yes 2 🗷 No Month Day Year 1 ☐ Yes ∠⊭ g ☐ Unknown detached 9 Unknown Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by ATRIAL FIBRILLATION RENAL FAILUR 1 ☐ Yes 2 🔀 No 3 ☐ Probably 4 ☐ Unknown should 24b. Were autopsy findings available prior to completion of cause of 24a. Was an performed? death? Yes 2 No To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifica completed filled in by the funeral director, To Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Death Certificate: 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Accident 5 Pending 1 Yes 2 No Investigation 3 Suicide
4 Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 1 🔀 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) D44542 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar

DHMH 17 Rev 7/2009

Baltimore, Maryland 21215-0036

Box 68760

Records,

of Vital

Division

200 MEMORIAL AVE, WESTMINSTER, ND 21157

RANGANATHAN, MD

Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death . Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ March 2:16PM Thomas John Stites Medical 4a. Facility Name (if not institution, give street and number) 4b. City. Town, or Location of Death **Examiner** 4c. County of Death Doctors Hospital Prince George's Lanham Social Security Numbe If Under 1 Year 7. Age (In vrs. last birthday) If Under 24 Hrs. **Funeral** 8. Date of Birth 9. Birthplace (State or Foreign (Month, Day, Ye 1 🖾 M 2 🗆 F Days Hours Min 1960 Williamsport,PA **Director** 218-90-7470 50 Nov. Usual Residence of Decedent 10a. State death with the Maryland "natural", or items 23a or 28a-f sho edical Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits Director 1 🗌 Yes 2 🕱 No MD Prince George's Adelphi 10e. Street and Number 10f. Zip Code 10a, Citizen of What Country? Funeral 1716 Merrimac Drive 20783 Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Was Decedent Ever in U.S. 14. Race - American Indian. Armed Force Black, White, etc. Yes 2 X No f Yes, Give þ 1 X Never Married 2 ☐ Married filed within 72 hours after 1 ☐ Yes 2 🛛 No Specify: Completed 3 Widowed 4 Divorced Specify: White Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Prince George's County Elementary/Seconday (0-12) College (1-4 or 5+) 12 Umpire Boys & Girls Club Be Baltimore, Maryland 17. Father's Name (First, Middle, Last) . Page 1 and 2 should be filed tment of Health and Mental He tant: If item 27 is marked ot 18. Mother's Name (First, Middle, Maiden Surname) Richard Thomas Stites Dorothy Elizabeth Jones 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Tod Stites / Brother 1716 Merrimac Drive, Adelphi, MD 20783 Important: If item 2 any injury or other 20a Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 1
Burial 2
Cremation 3
Removal from State permit. Page Department 4 ☐ Donation 5 ☐ Other (Specify) Metropolitan Crematory 4/2/2011 Alexandria, Virginia 21. Signature of Funeral Service Licensee 22. Name and Address of Facility 4739 Baltimore Avenue danning Gasch's Funeral Home, P.A. Hyattsville, MD 20781 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line Immediate Cause (Final Onset and Death Physician/ disease or condition resulting in death) Cardiac Arrhythmia Medical Due to (or as a consequence of Examiner Pulmonary Embolism Sequentially list conditions. Examine if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of) Cause (Disease or linjury sate has been signed by the attending physician and page 2 should be detached for use as the burial-trans that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Division of Vital Records, P.O. Box 68760 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?
1 ☐ Yes 2 ☐ No Month Year Day Pregnant at time of death Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Colonic Polyps 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🛣 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy death? I or Attending Physician; The after death.

Director: After this certificate I 1 Yes 2 No 2 X No Yes completed filled in by the funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 1 X Yes 2 No မ 1 M Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28c. Injury at Certificate: 28b. Time of 28d. Describe how injury occurred 1 🛚 Natural 5 Pending 1 Yes 2 No Accident Suicide Investigation Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide City or Town, State) Medical 🗵 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check 3 🗆 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29d. Date signed (Month. Dav. Year) D19591 March 31, 2011 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Thong Limpuangthip, 7721 Belle Point Drive, Greenbelt, MD 20770 APR 0 4 2011 31. Date filed (Month, 32. Registr State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ March 25° Carrie Bell Bowman Simmons 2011 4:19 A. M Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Magnolia Center Nursing Home Lanham Prince Georges Social Security Number 8. Date of Birth (Month, Day, Year) July 5,1918 6. Sex If Under 1 Year If Under 24 Hrs. **Funeral** 7. Age (In vrs. last birthday) 9. Birthplace (State or Foreign 1 🗆 M 2 🗶 F Days Hours Min 92 Director 577-34-6205 South Carolina Usual Residence of Decedent items 23a or 28a-f show ner must be notified at permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "--- any injury or other than any injury or other than 10a. State 10h Counts 10c. City, Town or Location Director 10d. Inside City Limits Maryland (Prince Georges Lanham 1X Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 10024 Ellard Drive 20706 United States 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian. Black, White, etc. 1 Never Married 2 X Married þ Yes Yes, Give 1 ☐ Yes 2 No Specify: 3 🗆 Widowed 4 🗆 Divorced Completed Specify: **Black** Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) Georgetown University Elementary/Seconday (0-12) College (1-4 or 5+) Licensed Practical Nurse **Hospital** vears Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Holmes Johnnie Rowman Essie Lue 19a Informant's Name/Relationship (Type, Print) & Willie Simmons (Husband) & 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 10024 Ellard Drive; Lanham, Maryland 20706 Juanita Simmons White (Daughter) 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State March 31. 1 X Burial 2 Cremation 3 Removal from State cemetery, crematory or other place, 4 ☐ Donation 5 ☐ Other (Specify) Fort Lincoln Cemetery 2011 Brentwood, Maryland Signature of Funeral Service Mame and Address of Facility R. N. Horton Company Morticians, Inc.: 600 Kennedy Street, N.W.; Washington, D.C. 2001 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. terval Between Immediate Cause (Final Physician Dehydration disease or condition hours Medical resulting in death) Due to (or as a consequence of): Examiner Renal Failure days Sequentially list conditions Examine Due to (or as a consequence of) if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events g physician and as the burial-transit the Hospital or Attending Physician: The law requires that the death certificate be executed Hypertension Due to (or as a consequence of): resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 attending p IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?

1 Yes 2 No 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ Month Day Year Pregnant at time of death s been signed by the should be detached Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Dementia 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 X Unknown 24b. Were autopsy findings available prior to completion of cause of death? Alzheimer's 24a. Was an this certificate has al director, page 2 performed? Yes 2 X No 25. Was case referred to medical funeral director, Be 26. Place of Death (Check only one) examiner? Other: 1 Yes 2 X No ည 1 Inpatient 2 ER/Outpatient 3 DOA 4 X Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28b. Time of 28a. Date of injury (Month, Day, Year) 28c. Injury at Certificate: 28d. Describe how injury occurred X Natural 5 Pending work 1 Yes 2 No Accident Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide determined 24 hours a Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 06858 , 2011 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) M.D.; 8200 Good Luck Road; Lanham, Maryland 20706 Tanyech Walford,

Registrar
DHMH 17 Rev 7/2009

State

31. Date filed (Month

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day 2011 Physician/ Month Robert Westley Smith, Jr. 12:30 P M March Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death 1912 McHenry Street Baltimore 6. Sex 1 🔀 M 2 🗆 F 5. Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Ye Feb. 10, 7. Age (In yrs. last birthday, 9. Birthplace (State or Foreign **Funeral** Year) 1946 Days Months Hours Min . Virginia 65 Director Feb. 220-42-1658 Usual Residence of Decedent iral", or items 23a or 28a-f show Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 X Yes 2 No Baltimore Maryland 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral United States 21223 1912 McHenry Street 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Forces?

1 Yes 2 No Black, White, etc. 1 Never Married 2 Married þ If Yes, Give Year or Dates 1 Yes 2 No Specify: Black Specify: "natural" 3 Divorced 4 Divorced Completed traumatic event, the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) and Mental Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) 4 Social Worker Private Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname, 1 and 2 should be fill of Health and Mental fitem 27 is marked ဂ္ Robert Westley Smith, Sr. Mary E. Wood 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 20744 3015 Ramsgate Place Fort Washington, Md. permit. Page 1 and 2 Department of Health Important: If item 27 any injury or other tr Barbara D. Johnson - Sister 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other place) 1 Burial 2 X Cremation 3 Removal from State April 5, 4 ☐ Donation 5 ☐ Other (Specify) Lee's Crematory Clinton, Maryland 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Stewart Funeral Home, 7 4001 Benning Road NE Washington, DC 23 Port 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) cance 9 MONTH Medical Due to (or as a consequence of): **Examiner** IRRH051S 11 YEARS Sequentially list conditions. Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury Due to (or as a consequence of): MORE THAN Physician: The law requires that the death certificate be executed the burial-transit PATITI 30 YEARS that initiated events resulting in death) Last Due to (or as a consequence of) nding physician Physician/Medical for use as IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?
1 ☐ Yes 2 ☐ No Pregnant at time of death Month Year Day signed by the at d be detached for 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by HYPERTENSION 1 Yes 2 No 3 Probably 4 Unknown 2 should 24b. Were autopsy findings available prior to completion of cause of 24a. Was an Was an autopsy performed. SMOKING page death? 2 💢 No 1 Yes 25. Was case referred to medical examiner?

1 ☒ Yes 2 ☐ No funeral director, Be 26. Place of Death (Check only one) Other: 4 \square Nursing Home 5 \boxtimes Residence 6 \square Other (Specify) ည 1 Inpatient 2 ER/Outpatient 3 IDOA After this 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28c. Injury at work?
1 ☐ Yes 2 ☐ No 28b. Time of Certificate: 28d. Describe how injury occurred To the Hospital or Attending F within 24 hours after death. To the Funeral Director: After 1 X Natural 5 Pending injury М Accident Investigation the 3 Suicide
4 Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by determined Medical 🗷 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier сотріете 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) Kotinh MARCH 30, 2011 00060195 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) BALTIMORE, MD 720 RUTLAND AVE- ROSS 918 MD KOTEISH

DHMH 17 Rev 7/2009

State Registrar 31. Date filed (Month, Day, Year)

Baltimore, Maryland 21215-0036

Box 68760

P.O.

Records,

Division of Vital

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Amend Item State of Maryland / Department of Health and Mental Hygiene For State Certificate of Death 1. Decedent's Name (First, Middle, Last) Tawann Pasquale Simmons 2. Date of Death Physician/ Year Medical 5:46 PM Facility Name (if not institution, give street and number **Examiner** 4b. City, Town, or Location of Death 4c. County of Death University of Maryland Medical Baltimore Baltimore 5. Social Security If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. Number **Funeral** 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign Country) Washington, DC 220-94-3909 1 M 2 D F 40 Months Director Yrs. (Month, Day, Year /30/1971 Usual Residence of Decedent 28a-f shov 10b. County filed within 72 hours after death with the Maryland marked other than "natural", or items 23a or 28a-f sho matic event, the Medical Examiner must be notified at Director 10c. City, Town or Location 10d. Inside City Limits MD Prince George's Lanham 1X☐ Yes 2 ☐ No 10f. Zip Code 10g. Citizen of What Country? Funeral 9405 Wyatt Drive 20706 USA 11. Marital Status Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. þ Black, White, etc. Baltimore, Maryland 21215-0036 1 Never Married 2 Married 1 ☐ Yes 2 😾 No If Yes, Give Completed 3 Divorced 4 Divorced 1 ☐ Yes 2 🙀 No Specify: Specify: Black Year or Dates 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry Elementary/Seconday (0-12) College (1-4 or 5+) Software Engineer Private Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) and Mental ٩ 27 is marke traumatic <u>Charlie G. Simmons</u> Geraldine R. Miller 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) f Health item 27 Geraldine R. Simmons/Mother 9405 Wyatt Drive Lanham, MD 20706 injury or other 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) permit. Page 1 a
Department of F
Important: If ite
any injury or ott 20c. Location - City or Town, State 1 KBurial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Maryland National 04/09/2011 Laurel, MD Signature of Funeral Service Licensee 22. Name and Address of Facility Marshall-March Funeral Home 4308 Suitland Road Suitland, MD 20706 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician, disease or condition resulting in death) tulmitant Medical Due to (or as a consequence of) Examiner Fungemia Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or limitury that initiated events Date to (or as a consequence of). Exami sician and burial-trans that initiated events resulting in death) Last Due to (or as a consequence of): attending physician for use as the buria by Physician/Medical the Hospital or Attending Physician: The law requires that the death certificate be Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death

4 Pregnant at time of death 23b. Was decedent pregnant 3 Ectopic pregnancy
5 Other (specify) ____ 23d. Date of delivery in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day Year g Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, Certificate: To Be Completed 2 No 3 ☐ Probably 4 ☐ Unknown 1 Yes this certificate has been 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an 2 No 1 🗌 Yes Division of Vital 25. Was case referred to medical 26. Place of Death (Check only one) examiner? 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA 27. Mann of Death 28a. Date of injury within 24 hours after death.

To the Funeral Director, After completed filled in by the funer. 28b. Time of 28c. Injury at work? 1 ☐ Yes 28d. Describe how injury occurred Natural (Month, Day, Year) 5 Pending 2 Accident
3 Suicide Investigation 2 \square No 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 - Homicide determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29c. License number MD 19693 30. Name and address d person who completed cause of death (Item 23a) (Type, Print) Baltimore, MD

Registrar

State

31. Date filed (Month, Day, Year)

32. Registrar's Signature

Scilla MD

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day Month 11:35A M March 31 2011 **Physician** Shawver Lucille В. /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Frederick Frederick Heartsfields of Frederick Birthplace (State or Foreign Country) If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 7. Age (In yrs. last birthday) **Funeral** Months Days Hours 1 ☐ M 2 😿 F Feb. 12 1915 Maryland Yrs. 219-34-8669 96 Director Usual Residence of Decedent 10d. Inside City Limits the Maryland 10a. State 10b. County 10c. City, Town or Location 28a-f show or other traumatic event, the Medical Examinational be notified at 1 Yes 2 No Frederick Frederick Md. Director 10g. Citizen of What Country? 10f. Zin Code 10e. Street and Number ŏ United States 21701 1820 Latham Drive Items 23a death Funeral 14. Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: within 72 hours after 1 Never Married 2 Married 1 ☐ Yes 2 ☑ No Specify: Specify: White Baltimore, Maryland 21215-0036 5 þ 3 ⊠ Widowed 4 □ Divorced "natural", 16b. Kind of Business/Industry Completed 16a, Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) permit. Pages 1 and 2 should be filed within Department of Heatilt and Mental Hygiene. Important: if item 27 is marked other than any injury or other traumetic. College (1-4or 5+) Elementary/Secondary (0-12) County Court Deputy Secretary 12 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Mary Elizabeth Cashell Arthur Washington Brown 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 2213 Garden Lane, Frederick, Md. Arthur M. Fennington / Son 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a, Method of Disposition 1 Surial 2 □ Cremation 3 □ Removal from State Sunshine, Maryland 4/11/2011 Carmel Cemetery ^¹ 4 □Donation 5 □ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility
Muriel H. Barber Funeral Home 00470 P. O. Box 5038, Laytonsville, Md. 20882 m. 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, spock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final 1/10 **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): The law requires that the death certificate be executed burial-tran and Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, attending physicien Physician/Medical use as the 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal dea
4 Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 2 Fetal death 3 □Ectopic pregnancy Year Month Day for in the past 12 months? 5 Other (specify) ☐Yes 2☐No the 9 Unknown detached 9 Unknown s been signed by the should be detached 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 s autopsy performed? certificate has 2 No 2 No 1 Tes 1 Yes To the Hospital or Attending Physician: 26. Place of Death (Check only one) tor: After this certific the funeral director, Be 25. Was case referred to medical examiner? Other: 4 Nursing Home 5 Residence 6 Nother (Specify) Assisted Hospital: 2 ER/Outpatient 3 DOA 1 ☐ Yes 2 ☐ No 1 Inpatient ۵ 28d. Describe how injury occurred 28c. Injury at Work? 28a. Date of Injury (Month, Day Year) 28b. Time of 27. Manner of Death Certification: Injury 5 Pending investigation 1 (Natural 1 ☐ Yes 2 ☐ No М death. 2 Accident within 24 hours after death
To the Funeral Director:
completely filled in by the 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 Homicide 1 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 9

DHMH 17 Rev 1/2001

State

Registrar

Michael Costello, M.D.

31. Date filed (Month, Day, Year)

Mars Kal

32. Registrar's Signature

1564 Opossumtown Pike, Frederick, Md.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Amend # 5pfh04/08/2011ccdohrb Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Ma^{Month}h 3^{Pey} 201^Yf Bernard Columbus Taylor, Sr. 22:16P Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death Prince George's Fort Washington Ft.Washington Medical Center 5 Social Socurity Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign Birthpiac Country) MD **Funeral** 1 M 2 D F Hours 1 2 / 2 3 / 1 9 4 0 Director 70 42 3228 Usual Residence of Decedent "natural", or items 23a or 28a-f show edical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director Oxon Hill Prince George's 1 Yes 2 No MD 10e. Street and Number 10f, Zip Code 10g. Citizen of What Country? Funeral USA 20745 5814 Shoshone Drive death v 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian Armed Forces? Black White etc þ 1 Never Married 2 Married Saltimore, Maryland 21215-0036 Specify: Black 1 ☐ Yes 2 No Specify Completed 3 Widowed 4 Divorced Year or Dates event, the Medical 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) nould be filed within 72 and Mental Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) Transportation Specialist DCC/St.Eliz.Hosp. Be 17. Father's Name (First, Middle, Last, 18. Mother's Name (First, Middle, Maiden Surname) Should be file and Mental F Ersalete Shorte Michael Snowden 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1 and 2 sl of Health a item 27 i 5814 Shoshone Dr.Oxon Hill, MD 20745 Shirley Taylor/ Wife 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Department of Important: If it any injury or o 1 🔀 Burial 2 🗌 Cremation 3 🗌 Removal from State 4/7/2011 Landover, MD 4 Donation 5 Other (Specify) Harmony Mem.Cem. 22. Name and Address of FacilityBriscoe-Tonic Funeral Home 21. Signature of Funeral Service Licensee 2294 Old Washington Rd.Waldorf, MD 20601 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line Immediate Cause (Final theroscleratic Coronary Onset and Death 1) iseuse Physician disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to increaling cause. Enter Underlying Due to (or as a sur sequence of): Examir Cause (Disease or linjury that initiated events resulting in death) Last that the death certificate be executed and Due to (or as a consequence of): attending physician for use as the buria Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) ____ in the past 12 months? 4 ☐ Pregnant at time of death 9 ☐ Unknown Day signed by the a Id be detached f 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by pertension Hospital or Attending Physician: The law requires 2 No 3 Probably 4 Unknown Mellitus Were autopsy findings available prior to completion of cause of 24a. Was an has autops, performed? Yes 2 No page this certificate 1 ☐ Yes 2 ☐ No Be 25. Was case referred to medical 26. Place of Death (Check only one) Hospital 2 No 1 🗌 Yes မှ 1 ☐ Inpatient 2/☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 1 Natural 28a. Date of injury 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred (Month, Day, Year) injury work?
1 Yes 2 No 5 Pending s after death.

I Director: Aff 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined thin 24 hours after the Funeral Dire Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner. The best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature a D46741 April 2011 MD 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Dr.Deepak Sachdeva 11711 Livingston Rd.Ft.Washington, MD 20744-5164 31. Date filed (Month, Day, Year) State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 2035 lizabeth Wagner 04 201 M Medical 4a. Facility Hame (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Baltimore, Maryland of Maryland Medical Center 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 □ M 2 🕶 F Hours JAR-1LAND Director "natural", or items 23a or 28a-f show edical Examiner must be notified at 10b. County 10a. State 10c. City, Town or Location 10d. Inside City Limits filed within 72 hours after death with the Maryland Director 1 ☐ Yes 2 Mo 10e. Street and Number 10g. Citizen of What Country? Funeral 5.5 Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian Black, White, etc. 1 Never Married 2 Married ģ 2 No Yes Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify: If Yes, Give 3 Widowed 4 Divorced Completed Year or Dates the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working Il Hygiene. life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) of Health and Mental Hygie If item 27 is marked other or other traumatic event, tt Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) permit. Page 1 and 2 should be fill Department of Health and Mental Important: If item 27 is marked or any injury or other traumatic ew 2 EQUARD 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) RD-GLENBURNIE, MD. Z.OGI JARCIA HEID 516ELIZARETH Baltimore, 20a. Method of Disposition 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 1 Burial 2 Cremation 3 Removal from State 41-16-11 BALTIMORE, MT). 4 Donation 5 Other (Specify) 21. Sign Name and Address of Facility werety functed Home Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Onset and Death Immediate Cause (Final Ph_sician/ potension disease or condition Medical resulting in death) as a consequence of): Examiner Sequentially list conditions, if any, each of the introduction cause. Enter Underlying Cause (Disease or iinjury Examiner r as a consequence of): To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director. After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burlar-transit that initiated events Due to (or as a consequence of) resulting in death) Last Be Completed by Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23d Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months?
1 Yes 2 No Pregnant at time of death 9 Unknown Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Renal failure 1 Yes 2 No 3 Probably 4 Unknown Peripheral Vascular Disease 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 No 1 ☐ Yes 2 No 25. Was case referred to medical 26. Place of Death (Check only one) examiner? 1 ☐ Yes 2 🗷 No Hospital Other: Certificate: To 1 XInpatient 2 - ER/Outpatient 3 - DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28b. Time of 28c. Injury at work? 1 Natural 28a. Date of injury 28d. Describe how injury occurred (Month, Day, Year) 5 Pending injury 2 Accident
3 Suicide
4 Homicide 1 Yes 2 No Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined Medical 29a, Certifier 1 💢 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 2 | medical Examiner: Of the basis of examination and of involving and the time, date and place, and due to the cause(s) and manner as stated.

3 | Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one)

DHMH 17 Rev 7/2009

State Registrar 29b. Signature and title of certifier

LEUR 31. Date filed (Month, Day, Year)

ERIC

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 22 50054

SIREET

GREENE

32. Registrar's Signature

29c. License numbe

D69161

RACTIMORE MD

29d. Date signed (Month, Day, Year)

21201

2011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygien For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ March 27, Day 2011 05:37 A M Steven Ronald Walker Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death Prince George's Clinton Southern Maryland Hospital Social Security Number 7. Age (In vrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 🖾 M 2 🗆 F Months Days Hours Min Month Day, Yea DC Director 579-70-0070 May Usual Residence of Decedent or 28a-f show notified at 10a. State 10b. County with the Maryland 10c. City, Town or Location 10d, Inside City Limits Director Capital Heights 1 X Yes 2 ☐ No Prince George's Maryland 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ö ıral", or items 23a o Examiner must be Funeral United States 20746 6904 Valley Park Road death v 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, 11. Marital Status med Forces?

Yes 2 No Black, White, etc. 1 Never Married 2 Married ģ Maryland 21215-0036 hours after African If Yes, Give Year or Dates 1 Yes 2 No Specify: "natural", Completed 3 Widowed 4 Divorced the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working Hygiene. life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) 12th Driver Private ulth and Mental Hygien 27 is marked other t r traumatic event, the Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Georgia James Theodore Walker permit. Page 1 and 2 should be Department of Health and Ment Important: If item 27 is marke any injury or other traumatic once. 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) ~207477314 Donnell Place C-7 Forestville, Maryland Betty McQueen - Sister Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of April s 20c. Location - City or Town, State Maryland Veterans Cemetery 1 X Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Cheltenham, Maryland 2011 Stewart Funeral Home, Inc. 21. Signature of Funeral Service Licenses Washington, DC 20019 4001 Benning Road NE art 1. Enter the disease, or complications that caused the shock, or heart failure. List only one cause on each line. eath. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Immediate Cause (Final Onser and Death Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of): xaminer STAO Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Cause (Disease or iinjury that initiated events resulting in death) Last the burial-transit for as a consequence of) attending physician for use as the burial Physician/Medical The law requires that the death certificate be Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months?
1 ☐ Yes 2 ☐ No Pregnant at time of death Month Day Year been signed by the a should be detached t P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ ☐ ☐ Known Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an page 2 s has performed 1 ☐ Yes 2 ☐ No certificate Division of Vital Hospital or Attending Physician: 25. Was case referred to medical director Be 26. Place of Death (Check only one) examiner? Hospital: Other: 1 Yes 2 WNo 2 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) After this within 24 hours after death.

To the Funeral Director: After the completed filled in by the funeral 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 5 Pending Natural work? 1 Yes 2 No Investigation Accident Suicide Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one 29b. Signature a 29c. License number 29d. Date signed (Month, Day, Year) th (Item 23a) (Type, Print) 30. Name and address of pe 207

Registrar

DHMH 17 Rev 7/2009

State

filed (Month,

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene for State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Year Physician/ 2011 Robert Jay Alperin Apri Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Prince George's Prince George's Medical Center Cheverly 5. Social Security Number If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign 6. Sex 8. Date of Birth 7. Age (In vrs. last birthday) Funeral Days 1 🗙 M 2 🗆 F Hours (Month, Day, Year) 01/01/1929 <u>Tennessee</u> Director 141-22-9424 82 Usual Residence of Decedent shov permit. Page 1 and 2 should be filed within 72 hours after death with the Manyland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho any injury or other traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 X Yes 2 No Prince George's Largo 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 20774 U.S.A. 600 Largo Road Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian Armed Forces? Black, White, etc. ģ 1 X Never Married 2 Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 Yes 2 X No Specify: Specify: Completed 3 Widowed 4 Divorced White 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b, Kind of Business Industry (Give kind of work done during most of working life. DC NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) 5+ University Professor Education Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) ၉ David Alperin Jeanette Seagal 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Plateau, Unit A, Greenbelt, MD 20770 Caroline Nevins / Friend 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 1 Burial 2 Cremation 3 Removal from State 04/18/2011 Hanover, Maryland 4 X Donation 5 ☐ Other (Specify) Anatomy Gifts Registry 22. Name and Address of Facility Anatomy Gifts Registry 7522 Connelley Dr., Ste. P, Hanover, MD 21076 or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest tonly one cause on each line. 23a. Part 1. Enter the d shock, or heart fail Immediate Cause (Final Onset and Death Physician/ disease or condition Medical resulting in death) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to wr as a consequence of) Hospital or Attending Physician: The law requires that the death certificate be executed burial-transi Cause (Disease or iinjury and that initiated events resulting in death) Last Due to (or as a consequence of): attending physician for use as the buria Physician/Medical P.O. Box 68760 IF FEMALE: yes, outcome of pregnancy

Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months?
1 ☐ Yes 2 ☐ No Pregnam
Unknown Month Day Year Pregnant at time of death signed by the a d be detached for Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Be Completed by Division of Vital Records, 1 Yes 2 No 3 Probably 4 Unknown should peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performed page 2 1 Yes 2 No 25. Was case referred to predical 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No ပ္ 1 🗌 Yes 1 Inpatient 2 PER/Outpatient 3 I 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at work? 1 ☐ Yes 2 ☐ No 28d. Describe how injury occurred 1 Natural injury 5 Pending Accident Investigation 6 \square Could not be 3 Suicide 4 Homicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) determined

24 hours after death.

Funeral Director, After this certificate I completed filled in by the funeral director, Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Confirming Number Practice of the best of my frontedge, death confirming state of the date at 2 place, and due to the cause(s) and memory analysis. (Check within 2 To the I 29b. Signature filed (Month, Day, Year) APR 19 201 State

Registrar

29d. Date signed (Month, Day, Year

201

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Ttem 12 per 1h g914 4-26-11 vt. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No 2 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 2011 John C. Arrington Sr. April 2:20a Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death Examiner 4b. City, Town, or Location of Death Future Care North Point Baltimore Dundalk Social Security Number 9. Birthplace (State or Foreign Country) North Carolina 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, **Funeral** Days 1 M 2 D F Months 239-18-2615 **Director** 93 January 16,1918 Carolina Usual Residence of Decedent 28a-f shov 10a State 10b. County or than "natural", or items 23a or 28a-f sho the Medical Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits Director Md. Baltimore Dundalk 1 Yes 2 X No 10e Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 1953 Merritt Blvd. 21222 USA death 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Armed Forces?

1 Yes 2 1 No Black, White, etc. þ 1 Never Married 2 Married Maryland 21215-0036 within 72 hours after If Yes, Give Year or Dates. 1 Yes 2X No Specify. White Specify: ted 3 Nidowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) Complet 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) and Mental Hygiene. is marked other than Elementary/Seconday (0-12) College (1-4 or 5+) Pipefitter 12 years Beth Steel event, Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ی John Evan Arrington Florence Neile Stewart injury or other traumatic 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 sh Department of Health ar Important: If item 27 is any injury or other trau Victoria A. Gilliam Daughter 9105 Wise Ave. Sparrows Point, Md. 21219 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State April 21, cemetery, crematory or other place) 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 D Other (Specify) Rosedale, Maryland Gardens Of Faith 2011 ign in re of Funeral Service Licens Name and Address of Facility
Connelly Funeral Home Of Dundalk, P.A
7110 Sollers Point Road, Dundalk, Md. Part 1. Enter the disease or complications that caused the shock, or heart failure. Ust only one cause on each line. eath. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Immediate Cause (Final HNEWIA Physician/ disease or condition Medical resulting in death) cxaminer Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of): Cause (Disease or iinjury that initiated events resulting in death) Last and Due to (or as a consequence of): burial physician Physician/Medical that the death certificate be Box 68760 the as attending IF FEMALE: Se yes, outcome of pregnancy
Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) in the past 12 months? jo Month Year Pregnant at time of death ed by the a 2 No 9 Unknown P.O. been signed be should be deta Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ DEMENTIA Records, Completed 1 Yes 2 No 3 Probably 4 Onknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 s The law has autopsy performed certificate 1 ☐ Yes 2 ☐ No Yes Division of Vital Hospital or Attending Physician: 25. Was case referred to medical director, Be 26. Place of Death (Check only one) examiner? 2 No Other: ပ 1 Yes 1 Inpatient 2 I 4 Nursing Home 5 Residence 6 Other (Specify) ER/Outpatient 3 DOA funeral 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred 1 Natural 5 Pending work? 1 Yes 2 🗌 No within 24 hours after death

To the Funeral Director: A
completed filled in by the f Accident Investigation Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. To the only one) Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 9b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 00060560 s of person who completed cause of death (Item 23a) (Type, Print) Name and address 0 PHILADELPIAA RD 31. Date filed (Month, Day, Year) 32. Registrar's Signature State APR 1 9 2011

DHMH 17 Rev 7/2009

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State
Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2 Date of Death Physician/ April 17 Day 2011 Year James S. Albus 6:45 A M Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death 9520 W. Stanhope Road Kensington Montgomery 5. Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** 8. Date of Birth 1 🖾 M 2 🗆 F Days Hours Min. May 4, Day 1935 403-44-8973 75 Kentücky **Director** Usual Residence of Decedent or 28a-f shov notified at 10a. State 10b. County filed within 72 hours after death with the Maryland 10c. City. Town or Location 10d. Inside City Limits Director Maryland Montgomery 1 Yes 2 X No Kensington 10e. Street and Number 0 10f. Zip Code 10g. Citizen of What Country? Examiner must be items 23a Funeral 9520 W. Stanhope Road 20895 United States 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 🎛 No 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 0 þ 1 Never Married 2 X Married Baltimore, Maryland 21215-0036 Specify: White 1 ☐ Yes 2 X No Specify: Completed 3 Divorced Year or Dates 15. Decedent's Education 16b. Kind of Business Industry 16a. Decedent's Usual Occupation (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) and Mental Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) 5+ Research Scientist Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Page 1 and 2 should be George Albus Lucy Sacra 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Health a Cheryl Albus/Wife 9520 W. Stanhope Road, Kensington, Maryland 20895 item 2 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State permit. Page 1
Department of I
Important: If its
any injury or of o cemetery, crematory or other place)
Montgomery
Crematorium, Inc. 1 Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Bethesda, Maryland 22 Name and Address of Facility Robert A. Bethesda-Chevy Chase Inc. Bethesda, Maryland 20814 Pumphrey Funeral Home/ 7557 Wisconsin Avenue Signature of Funeral Service Licenses M01498 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Onset and Death **₽nysicia**m Lymphoma disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of) attending physician and for use as the burial-transi Cause (Disease of finju-that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Hospital or Attending Physician: The law requires that the death certificate be P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months? Month Year Pregnant at time of death Unknown g 🗌 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Division of Vital Records, 1 ☐ Yes 2 🛛 No 3 ☐ Probably 4 ☐ Unknown need 24b. Were autopsy findings available prior to completion of cause of 24a. Was an death? certificate 1 ☐ Yes 2 ☐ No Yes 2 No Be 25. Was case referred to medical 26. Place of Death (Check only one) Hospital 2 3 No ၉ 1 Tyes 1 Inpatient 2 I ER/Outpatient 3 I DOA 4 ☐ Nursing Home 5 X Residence 6 ☐ Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred injury 1 X Natural 5 Pending work? 2 No after death Director: / Accident Investigation 2 ☐ Accident
3 ☐ Suicide
4 ☐ Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, completed filled in by determined Medical 1 🔀 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month, Day, Year) D37142 April 18, 2011

Registrar
DHMH 17 Rev 7/2009

State

1355 Piccard Drive, Rockville, Maryland 20850

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Registrar's

Geoffrey Coleman, MD

APR 1 9 2011

31. Date filed (Month, Day, Year,

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene, 1 - State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month April Day 15 Bowersox Year Physician/ Gordon 2:00P M 201 Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death
Baltimore 4b. City, Town, or Location of Death Examiner Season's Hospice Randallstown 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Y Nov. 13, 9. Birthplace (State or Foreign **Funeral** 1 ₹ M 2 □ F Months Days Hours Min Year 1920 Maryland 216-12-8198 90 Director Usual Residence of Decedent 28a-f show 10d. Inside City Limits 10b. County 10a. State 10c. City, Town or Location Page 1 and 2 should be filed within 72 hours after death with the Maryland Funeral Director Examiner must be notified 1 ☐ Yes 2 TNo Pikesville MD Baltimore ъ 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 23a USA 21208 116 Sudbrook Lane 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian Armed Forces Black, White, etc. "natural", or þ 1 Never Married 2 Married White Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: 3 → Widowed 4 □ Divorced Completed Year or Dates the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) and Mental Hygiene. is marked other than Elementary/Seconday (0-12) College (1-4 or 5+) Construction Carpenter Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ္ Alverta Eckenrode Lawrence Bowersox 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 sh Department of Health ar Important: If item 27 is any injury or other trau Son Mark Bowersox 6519 St. Cecelia Drive; Midlothian, VA 20b. Place of Disposition (Name of cemetery, crematory or other place)
Druid Ridge Cemetery 20c. Location - City or Town, State 20a. Method of Disposition Date 1 X Burial 2 Cremation 3 Removal from State 4/20/2011 Pikesville, MD 4 Donation 5 Other (Specify) 22. Name and Address of Facility Sterling Ashton Schwab Witzke Funeral Home of Catonsville, Inc. Signature of Funeral Service Licensee MOIDSC 630 Edmondson Avenue; Catonsville, MD 21228 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final End. Stage Dementia Ph_sician/ disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions. Examiner if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of) Cause (Disease or linjury that initiated events resulting in death) Last attending physician and for use as the burial-tran Due to (or as a consequence of) Physician/Medical To the Hospital or Attending Physician; The law requires that the death certificate be Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d Date of delivery | Live Birth 2 | Fetal death 3 | Ectopic pregnancy | Pregnant at time of death 5 | Other (specify) ____ in the past 12 months?
1 ☐ Yes 2 ☐ No ed by the a Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Division of Vital Records, Certificate: To Be Completed Were autopsy findings available prior to completion of cause of 24a. Was an page 2 s autopsy performed? death? 1 Yes 25. Was case referred to medical 26. Place of Death (Check only one) examiner? 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 2 🗖 No Other: 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred Natural 5 Pending 1 Yes 2 No Accident Investigation Suicide 6 Could not be 3 ☐ Suiciae 4 ☐ Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f, Location (Street and Number or Rural Route Number determined hours after within 24 hours a

To the Funeral C Medical 1 💆 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month. Dav. Year) nskyapatrseM.D

State

Registrar DHMH 17 Rev 7/2009 31. Date filed (Month, Day,

barker

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

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Registrar's Signati

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4/14/11

MO 21209

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death April 13^{ay} Physician/ 2011 7:00 P.M Peggy Louise Bassler Medical 4a. Facility Name (if not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death **Examiner** Catonsville Baltimore 32 Pepperdine Circle If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday **Funeral** Days Min. 1 🗆 M 2 🔀 F Hours (Month, Day, March 7 Maryland Months 217-16-6910 ,1924 87 **Director** Usual Residence of Decedent "natural", or items 23a or 28a-f show edical Examiner must be notified at 10d. Inside City Limits permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at 10a. State 10c. City, Town or Location Director 1 🗌 Yes 2 😾 No Baltimore Catonsville 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? Funeral 21228 32 Pepperdine Circle USA 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Was Decedent Ever in U.S. Race - American Indian. 11. Marital Status Armed Forces?

1 Yes 2 No Black, White, etc. þ 1 Never Married 2 X Married Baltimore, Maryland 21215-0036 Specify: White 1 ☐ Yes 2 X No Specify: If Yes, Give Completed 3 Widowed 4 Divorced Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) 12 IT B&O Railroad Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Bessie Elizabeth Kane Charles King 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 32 Pepperdine Circle; Catonsville, MD 21228 Charles Bassler Husband 20a Method of Disposition 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 1 XBurial 2 Cremation 3 Removal from State Loudon Park Cemetery 4/16/2011 Baltimore, MD 4 Donation 5 Other (Specify) 22 Name and Address of Facility Sterling Ashton Schwab Witzke Funeral Home of Catonsville, Inc. 21. Signature of Funeral Service Licensee MOIDS th 1630 Edmondson Avenue: Catonsville 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest Approximate shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final [hysician/ METASTATIC UTERINE CARCINOSARCOM disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of) Cause (Disease or iinjury To the Hospital or Attending Physician: The law requires that the death certificate be executed sician and burial-trans that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical I attending physician Division of Vital Records, P.O. Box 68760 the IF FEMALE: use 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No Day Pregnant at time of death 5 Other (specify) Take Funeral Director: After this certificate has been signed by the a completed filled in by the funeral director, page 2 should be detached it g Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available 24a. Was an prior to completion of cause of death? autopsy 1 Yes 2 No Yes 2 No 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner?
1 Yes 2 No Other: 4 Nursing Home 5 🗷 Residence 6 🗌 Other (Specify) |은 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at Certificate: 1 🗷 Natural 5 Pending work? s after death. 1 Yes 2 No Accident Suicide Investigation 6 Could not be . Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 24 hours Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

31. Date filed (Month, Day, Year) APR 1 9 2011 Registrar

29b. Signature and title of pertifier

MD 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

29a. Certifier

(Check

32. Registrar's Signature

BAVIS COSGROVE, JULINS HOPKINS HOSPITHAL, 620 NORTH WOLFE STREET, BAUTIMORE, MS, 21287

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated

1 064931

29d. Date signed (Month, Day, Year)

APRIL, 18, 2011

3 Certifying Nurse Practioner. To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

11-02877

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

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Physician	7	 Decedent's Name (First, Middle 		ate of Death Ionth	Day	Year	3. Time of Death 1316 hrs										
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		4a. Facility Name (if not institution Suburban Hospital		<u> </u>			b. City, Town, or Rockville				Mont	gomery					
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21215-0036 July be filed within 7 Mental Hygiene. marked other than ie event, the Medica		Santos Barah 19a. Informant's Name/Relations		Una	band 1	19h Mailing	Address (Stree		a Ran		ner City or	Town State	Zin Code)				
Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho injury or other traumatic event, the Medical Examiner must be notified at once.	- 1	Margarito Anto			Dana		Broadwo										
e, N 1 and 3 Health item	ı	20a. Method of Disposition				e of Disposi	tion (Name of ce	metery,	Da April	te	20c, Locat		Town, State				
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altii mit.] partm ports		21. Signature of Funeral Service	Licensee			22, N	ame and Address	s of Facility					me, P.A.				
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Physician /Medical		23a/ Part I. Enter the disease, or failure. List only one cause	on each line.				e mode of dying,	such as car	diac or resp	piratory arre	st, snock, o	пеап	Between Onset and Death				
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Box 68760, a death certificate be the attending physici ed for use as the buri		F FEMALE: 3b. Was decedent pregnant in the		s, outcome e birth	of pregnanc	_	al death 3	Ectopic p	oregnancy		Mont	te of deliver th	y Day Year				
lox 6 leath cer e attendi for use		past 12 months? 1 Yes 2 No 9 ✔ Unit		-	me of death	5 Oth	ner (Specify)										
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f Vital Physician or this certinal director	5	examiner? 1 ✓ Yes 2 No	Hospital: 1	Inpatient	2 🗹 ER/	/Outpatient	3 DOA	Other ₄ _ I	Nursing Ho	me 5 🗌 F	Residence	6 Othe	r:				
ling Pl	ŀ	27. Manner of Death 1 X Natural 5 Deach	(Mo	ite of Injury nth, Day,Yea		b. Time of In		ry at Work?		. Describe h	ow injury od	curred					
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Division of spiral or Attending Jours after death. neral Director: After filled in by the funer		dete	d not be 286. Pl	_	ry - At nome,	, rarm, stree	t, factory, office b	building, etc.	201.	or Town, St		umber of Ru	aran Route Number, City				
Hospit 4 hour Funers		4 Homicide 29a. Certifier 1 Certifying Pl	hysician: To the b		knowledge, o	death occum	ed at the time, d	ate and place	e, and due	to the cause	e(s) and ma	nner as stat	ted.				
Divis To the Hospital or A within 24 hours after To the Funeral Dire completely filled in b	2		miner:On the bas and manne	is of exami													
To with	Ĕ	29b. Signature and title of certifie				***	29c. Licens						onth, Day, Year)				
	((Calulelle) O.C.M.E.									April 16	, 2011					
ok 1	3	30. Name and address of person Laron Locke MD. A	who completed co				Street, Baltir	more MD	21201								
panel.	6	31. Date filed (Month, Day, Year)			Signature		Onco, Daitii		201								
Registra	-	APR 1 9 2011	Denna	A. 1	park												

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March F/H West
4300 Wabash Ave, 21. Sig sture of Funeral Service Licensee Baltimore, Approximate Interval Between Onset and Death 23a. Part J. Enter the filease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Ph sician/ rneumon & Struk aureus disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine burial-transit To the Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or linjury that initiated events and Due to (or as a consequence of resulting in death) Last physician the burial Physician/Medical Division of Vital Records, P.O. Box 68760 as IF FEMALE: nse 23c. If yes, outcome of pregnancy
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4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) for in the past 12 months? Month Dav Year ate has been signed by the page 2 should be detached 1 ☐ Yes 2 9 ☐ Unknow Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 YN 1 ☐ Yes 2 ☐ No 25. Was case referred to medica Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Tes 1 Inpatient 2 ER/Outpatient 3 DOA ဂ္ After this within 24 hours after death.

To the Funeral Director: After thi completed filled in by the funeral 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred Natural 5 Pending Accident 1 🗌 Yes 2 No Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) ☐ Homicide determined Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check 3 □ Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certi 3812 MD 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Baltimore, Maylard 21215 Haron 31. Date filed (Month, Day, Year)

DHMH 17 Rev 7/2009

State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State
 Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) ^{Day} 2<u>011</u> April Physician/ Brodowski 2:08 A M Emilia 14. Medical 4c. County of Death 4a. Facility Name (if not institution, give street and number, 4b. City, Town, or Location of Death Examiner Baltimore White Marsh Brightview at White Marsh If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign 8. Date of Birth Social Security Number 6. Sex 7. Age (In yrs. last birthday) Funeral Country)
Maryland Min. August 29 1 □ M 2 X F 90 **.** 1920l Director 220-14-3820 Usual Residence of Decedent show 10d. Inside City Limits permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho any injury or other traumatic event, the Medical Examiner must be notified at agnee. 10b. County 10c. City, Town or Location 10a. State Director Middle River Baltimore Maryland 1 Yes 2 XNo 10e. Street and Number 10f, Zip Code 10g. Citizen of What Country? Funeral USA 21220 3518 Buckboard Lane 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 12. Was Decedent Ever in U.S. Armed Forces? Black, White, etc. Completed by 1 Never Married 2 Married 1 ☐ Yes 2 ☐XNo If Yes, Give Baltimore, Maryland 21215-0036 White 1 ☐ Yes 2 💢 No 3 ☒ Widowed 4 ☐ Divorced Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) College (1-4 or 5+) Elementary/Seconday (0-12) Own Home Housewife 8 years Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Maryanna Mekoln August Pencek 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code 19a. Informant's Name/Relationship (Type, Print) 3518 Buckboard Lane, Middle River, Maryland 21220 John Brodowski 20b. Place of Disposition (Name of cemetery, crematory or other place)
Bayview Crematory 20c. Location - City or Town, State 20a, Method of Disposition Aprilate15, 1 Burial 2 Cremation 3 Removal from State Baltimore, Maryland 2011 4 Donation 5 Other (Specify) 21. Signature of Funeral Servi ^{22. Name and Address of Facility} Home Of Dundalk, P.A. 7110 Sollers Point Road, Dundalk, MD. 21222 23a. Part 1. 5 fter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Enysician** Medical Due to (or as a consequence of) Examiner Sequentially list conditions, Examine Due to (or as a consequence of) cause. Enter Underlying Cause (Disease or linjury the Hospital or Attending Physician: The law requires that the death certificate be execute that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 phy: the IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death
4 Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months? Month Day Year Pregnant at time of death 1 Yes 2 No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ FRLIPIDEMIA 1 Tes 2 No 3 Probably 4 Onknown Completed 24b. Were autopsy findings available 24a, Was an prior to completion of cause of death? performed 2 No 1 Nes 25. Was case referred to medical examiner? funeral director, 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Tes 2. 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA ည Date of injury (Month, Day, Year) 28c. Injury at work? 1 ☐ Yes 2 ☐ No 27. Manner of Death Natural 28b. Time of 28d. Describe how injury occurred Certificate: 5 Pending 24 hours after death. Funeral Director: A Accident Investigation 6 Could not be 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) completed filled in by 4 Homicide determined Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check within 2 To the F only one) 29d. Date signed (Month Day, Year) 29c. License number 29b. Signature and title of certifier 21042 what elvive 31. Date filed (Month, Day, Year) APR 1 9 2011 32. Registra 's Sign State

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death April . 2<u>011</u> Physician/ Broll 15 9:45 Wilma M. A^{M} Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 2114 Cockspur Road Middle River Baltimore Social Security Numbe 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 🗆 M 2 🔀 F Months Days West" Virginia 232-54-4927 0172271934 Director Usual Residence of Decedent 28a-f show 10a. State permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked of other than "natural", or items 23a or 28a-f sho any injury or other traumatic event, the Medical Examiner must be notified at any injury or other traumatic event, the Medical Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits Director Middle River 1 Yes 2 No Maryland Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21220 U.S.A. 2114 Cockspur Road Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian, Armed Forces?

1 Yes 2 No Black, White, etc. þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 X No Specify: 3 ₩idowed 4 ☐ Divorced Specify: White Completed 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Restaurant Cook 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Magsalene Logsdon Eugene Melvin 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 216 Ivy Lakes Drive, Jacksonville, Florida 32259 Richard Broll (Son) 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 M Burial 2 Cremation 3 Removal from State Holly Hill Mem. Gard 04/18/2011 Baltimore, Maryland 4 Donation 5 Other (Specify) 22. Name and Address of Equipment of P.A. 1407 Old Eastern Avenue, Essex, Maryland 21221 Signature of Funeral Service Licensee 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Atheroscleratic Physician/ disease or condition resulting in death) Cordiovasculor Medical Due to (or as a consequence of Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of): Exami Cause (Disease or iinjury that initiated events resulting in death) Last and burial-trar Due to (or as a consequence of): physician s the burial Physician/Medical Box 68760 attending p IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) in the past 12 months?

1 Yes 2 No
9 Unknown Month Day Year been signed by the a should be detached f 9 Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of 24a. Was an has autopsy performed death? 1 Yes 2 No the Hospital or Attending Physician: director. 25. Was case referred to medical Division of Vital Be 26. Place of Death (Check only one) 1 ☐ Yes 2 ☐ No Other: 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) within 24 hours after death.

To the Funeral Director: After thi
completed filled in by the funeral 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No 2 Accident
3 Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Under the date of the cause(s) and manner as stated.

Description of the date of the cause(s) and manner stated at the time, date and place, and due to the cause(s) and manner stated at the time, date and place, and due to the cause(s) and manner stated at the time, date and place, and due to the cause(s) and manner stated at the time, date and place, and due to the cause(s) and manner stated at the time, date and place, and due to the cause(s) and manner stated at the time, date and place, and due to the cause(s) and manner stated at the time, date and place, and due to the cause(s) and manner stated at the time, date and place, and due to the cause(s) and manner stated at the time, date and place, and due to the cause(s) and manner stated at the time, date and place, and due to the cause(s) and manner stated at the time, date and place, and due to the cause(s) and manner stated at the time, date and place, and due to the cause(s) and manner stated at the time, date and place, and due to the cause(s) and manner stated at the time, date and place, and due to the cause(s) and manner stated at the time, date and place, and due to the cause(s) a 29a. Certifier (Check 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29d. Date signed (Month, 01 30. Name and address of person vinc completed cause of death (Item 23a) (Type, Print) Battinune MD 4 Macs hh ed (Month, Day, Year, 32. Registrar's Signature 19 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State
Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Margaret D. Biddison 7:45 April 2011 Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Harford Memorial Hospital Havre de Grace Harford 5. Social Security Number 7. Age (In yrs. last birthday If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Days 1 M 2 X F Months Hours Min. (Month, Day, Year) Auq. 5, 1927 215 24 0924 **Director** 83 Pennsylvania Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits notified at Director 28a-f Maryland Harford Aberdeen 1 ☐ Yes 2 🌠 No 10e. Street and Number 10f. Zip Code ō 10g. Citizen of What Country? be ms 23a must be Funeral 1926 Fletcher Rd. 21001 **USA** items be filed within 72 hours after death Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian, Black White etc. ō þ 1 Never Married 2 Married Yes 2 XNo Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify: White "natural", Completed 3 X Widowed 4 ☐ Divorced Year or Dates ge 1 and 2 should be filed within 72 hour nt of Health and Mental Hygiene. : If item 27 is marked other than "natur or other traumatic event, the Medical 15. Decedent's Education 16a, Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Baltimore County Cafeteria Worker 12 Government Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Vincent Ellsworth Dora Burkhardt 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Susan Barwick (Daughter) 1926 Fletcher Rd. Aberdeen, Maryland 21001 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Department of h Important: If ite any injury or oth Holly Hill Mem. Gardens 4/19/2011 1 K Burial 2 Cremation 3 Removal from State Baltimore, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service License 22. Name and Address of Facility
Bruzdzinski Funeral Home P.A. 1407 Old Fastern Avenue Essex Maryland 21221 23a Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Immediate Cause (Final Onset and Death Physician/ TNEUMONIA disease or condition Medical resulting in death) Examiner Right MIDDLE CEREBRAL ARTERY DISTRIBUTION Sequentially list conditions, Examine Due to (or as a consequence of) if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury t een signed by the attending physician and should be detached for use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of) Completed by Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) ____ in the past 12 months?
1 Yes 2 No Pregnant at time of death 9 Unknown 9 🗌 Unknown Part II. <mark>Other significant conditions</mark> contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? FIBRILLATION with RAPID VENTRICULAR 1 ☐ Yes 2 🔀 No 3 ☐ Probably 4 ☐ Unknown has teen KIDNEY DISEASE 24b. Were autopsy findings available prior to completion of cause of death? ChRONIC 24a. Was an performed? certificate 1 Yes 2 No completed filled in by the funeral director, 25. Was case referred to medical To Be 26. Place of Death (Check only one) examiner? 2 No Other: 1 X Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at work? 28d. Describe how injury occurred 1 Natural
2 Accident
3 Suicide
4 Homicide 5 Pending 1 ☐ Yes 2 ☐ No Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) To the Hospital within 24 hours a To the Funeral D Medical 1 X Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 29b. Signature and title of certifier 19583 30. Name and address of person who completed cause of death (Item 23a) (Type, Print 8 Maw 32. Registrar Signatu Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Registrar 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Thomas Herbert Bennett 8:07A M 04 2011 Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City. Town, or Location of Death 4c. County of Death Tate Hospice House Anne Arundel Linthicum Social Security Number 9. Birthplace (State or Foreign Country) Germany 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth **Funeral** 1 🕅 M 2 🗆 F Months Days Hours Director 07/09/1957 Germany 228-92-1473 53 Usual Residence of Decedent 28a-f show 10a. State 10c. City, Town or Location r than "natural", or items 23a or 28a-f sho the Medical Examiner must be notified at 10d. Inside City Limits Director 1 Yes 2 X No Anne Arundel Glen Burnie 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 7520 Hollybrook Road 21061 U.S.A. 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Armed Forces?

1 XYes 2 No
If Yes, Give
Year or Dates. Black, White, etc. ģ 1 Never Married 2 Married Maryland 21215-0036 hours after 1 ☐ Yes 2 XNo Specify. 3 Widowed 4 Divorced Specify: Completed White 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) permit. Page 1 and 2 should be filed within 72 Department of Health and Mental Hygiene. Important: If item 27 is marked other than ' Elementary/Seconday (0-12) College (1-4 or 5+) 12 Associate NSA Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Thomas other traumatic Bennett Else Friedrich 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Glen Burnie, MD 21061 7520 Hollybrook Road Mr. Bruce A. Bennett / Brother Baltimore, 20a Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State any injury or 1 ☐ Burial 2X Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Atlantic Crematory 04/19/2011 Glen Burnie, MD 21. Signature of Funeral Service Lig 22. Name and Address of Facility 1 2nd Avenue SW Glen Burnie, MD Singleton Funeral & Cremation Services, PA 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Onset and Death Physican CEREBROMSCUL disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Exam that the death certificate be executed the burial-transit Cause (Disease or iinjury that initiated events resulting in death) Last URO BL and Due to (or as a consequence of) attending physician Physician/Medical Box 68760 as IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death use 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) ____ detached for in the past 12 months? Pregnant at time of death Unknown 2 No 9 Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Records, Hospital or Attending Physician: The law requires Completed 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has page certificate 1 Yes 2 No Division of Vital 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital: 2 No ၉ 1 Tyes 1 Inpatient 2 ER/Outpatient 3 DOA 4
Nursing Home After this 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred work? 1 Yes 2 No injury 1 D Natural 5 Pending s after death. Accident Investigation the Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) completed filled in by 4 Homicide 28f. Location (Street and Number or Rural Route Number determined 24 hours a Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29c. License number 2106 30. Name and address of p son who completed cause of death (Item 23a) (Type, Print) SUD Day, Year egistrar's Signatur State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month :50 AM 2011 Medical **Examiner** 4b. City, Town, or Location of Death 4c. County of Death St. Apt. 513 Baltimore 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 □ M 2 💢 F Country) 0316 **Director** Usual Residence of Decedent Important: If item 27 is marked other than "natural", or items 23a or 28a-f shov any injury or other traumatic event, the Medical Examiner must be notified at 10b. County City, Town or Location 10d. Inside City Limits Funeral Director Yes 2 ☐ No Hmore 10f. Zip Code 10g. Citizen of What Country? 21201 USA Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian Black, White, etc. þ 1 Never Married 2 Married should be filed within 72 hours after and Mental Hygiene. 1 Yes 1 Tes 2 No 21215-003 Specify Black 3 Widowed 4 Divorced Completed Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) permit. Page 1 and 2 should be filed within 72 Department of Health and Mental Hygiene. Important: If item 27 is marked other than ' 4 or 5+) thivate Be Maryland 17. Father's Name (First, Middle, 18. Mother's Name (First, Middle, Maiden Surname) 19a. Informant's me/Relationship 904 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other p Burial 2 Cremation 3 Removal from State Woodlawn, MD 19-2011 Woodlawn Donation 5 D Other (Specify) Signature of Fiveral Service Licensee 22. Name and Address of Facility March F/H 1101 E. North Ave. 21202 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory Approximate Interval Between shock, or heart failure. List only one cause on each line. Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury Due to (or as a consequence of) the Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events Due to (or as a consequence of): resulting in death) Last attending physician a for use as the burial-Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Dav Year Pregnant at time of death 5 Other (specify)]Yes 2 ☐ No 9 🗌 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of deg Completed by Division of Vital Records, 1 🗌 Yes 2 No 3 Probably 4 Vinknown 24a. Was an 24b. Were autopsy findings available certificate has b lirector, page 2 sh prior to completion of cause of death?

1 Yes 2 No autopsy Be 26. Place of Death (Check only one) 2 No 은 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home Residence 6 Other (Specify) Certificate: 28a. Date of injury (Month, Day, Year) 28c. Injury at work? 1 ☐ Yes 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Natural 5 Pending injury 2 🗌 No Accident Investigation 6 Could not be determined 3
Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) within 24 hours after

To the Funeral Dire

completed filled in b Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifier (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death . Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Day P M William 2011 7:25 Medical Barrett April 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Suburban Hospital Montgomery Bethesda 7. Age (In vrs. last birthday If Under 24 Hrs. 8. Date of Birth (Month, Day, 9. Birthplace (State or Foreign **Funeral** 1 🖾 M 2 🗆 F Days September 27,1932 Pennsylvania 169-24-3247 **Director** 78 Usual Residence of Decedent 10a, State 10b. County 10c. City, Town or Location Director "natural", or items 23a or 28a-f s edical Examiner must be notified 1 Yes 2X No Maryland Montgomery Bethesda 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 20817 6607 Elgin Lane United States 12. Was Decedent Ever in U.S. Armed Forces? 1 ☑ Yes 2 ☐ No If Yes, Give Year or Dates. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. ģ 1 Never Married 2 Married Maryland 21215-0036 1 Yes 2 No Specify: Specify: White Completed 3 Divorced 4 Divorced Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) of Health and Mental Hygiene. item 27 is marked other than other traumatic event, the Me Elementary/Seconday (0-12) College (1-4 or 5+) 5+ Physician Medicine Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Edward J. Barrett <u>Mary Egan</u> 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Amanda Barrett/ Daughter 2122 Albemarle Terrace, Brooklyn, New York 11226 permit. Page 1 and 2 Department of Healt Important: If item 2 any injury or other Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place)
Montgomery 20c. Location - City or Town, State Aprilate19, 1 Burial 2 X Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 2011 Crematorium. Inc. Bethesda, Maryland Signature of Fundal Service Licensee Robert A. Pumphrey Funeral Home, Bethesda-Chevy Chase, Inc. 7557 Wisconsin Avenue Bethesda, Maryland 20814 Retiz Mu MO1607 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Metastatic bladder cancer Physician/ Years Medical resulting in death) Due to (or as a consequence of): Examiner 1 day Peritonitis Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury Due to (or as a consequence of) Exam and burial-trar that initiated events Due to (or as a consequence of) resulting in death) Last ed by the attending physician detached for use as the burial Physician/Medical IF FEMALE yes, outcome of pregnancy
Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months? Month Day Year Pregnant at time of death Yes 2 No g Unknown g Unknown certificate has been signed by irector, page 2 should be detact Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Division of Vital Records, 1 Yes 2 No 3 Probably 4X Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? Be 25. Was case referred to medica n by the funeral director, 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 X No 은 1 Malignation 2 ☐ ER/Outpatient 3 ☐ DOA After this 28b. Time of 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28c. Injury at work? 1 ☐ Yes 2 ☐ No 28d. Describe how injury occurred Certificate: or Attending Fifter death. X Natural 5 Pending injury 2 Accident
3 Suicide
4 Homicide Investigation 3AR/ E11 24 hours after deat 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number. determined City or Town, State) Hospital 24 hours Medical 1 🔀 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 00059244 4-16-11 of death (Item 23a) (Type, Print) 30. Name and address of person who completed ca 6000 Executive Blud #302 Pocksille MD 2085 S MERY State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene, Certificate of Death 1. Decedent's Name (First, Middle, Last) Date of Death Physician/ BARNES AMIN Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** Baltimore Seasons Hospice at N.W. Hospital Randallstown Birthplace (State or Foreign Country) If Under 24 Hrs Hours Min 8. Date of Birth **Funeral** Days Min. 1 X M 2 🗆 F Months 07/22/1943 UNK Director 67 215-40-2373 Usual Residence of Decedent or 28a-f show 10a. State 10c. City, Town or Location 10d, Inside City Limits with the Maryland Examiner must be notified at Director 1 X Yes 2 No Baltimore MD 10e. Street and Number 10f Zin Code 10g, Citizen of What Country? ie 1 and 2 should be filed within 72 hours after death with to f Health and Mental Hygiene. If item 27 is marked other than "natural", or items 23a Funeral U.S.A. 2500 W. Belvedere Avenue 21215 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in LLS 14 Bace - American Indian 11. Marital Status Armed Forces? Black, White, etc. þ 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 🔀 No Specify: White If Yes Give Completed 3 Widowed 4 N Divorced the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Horse Racing Jockey Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Benjamin Barnes Doris Lambert 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Elizabeth Lambert (Aunt) 11374 Smith Hallow Rd., Broque, PA 17309 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Page 1 (Department of h Important: If ite 1 Burial 2 Cremation 3 Removal from State any injury or 4/15/11 Phoenix, AZ Science Care 4 X Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Harman Funeral Service 21. Signature of Furtiral Service Licensee 7221 Grayburn Dr., Glen Burnie, MD 21061 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Onset and Death Physician/ disease or condition resulting in death) Medical to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter I Inderlying Examine Due to (or as a consequence of) Cause (Disease or linjury To the Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-tran that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant Ectopic pregnancy in the past 12 months? Month Day Year Pregnant at time of death 5 Other (specify) 2 🗆 No signed by the a 1 ☐ Yes ∠ ☐ 9 ☐ Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 1 Yes 2 No 3 Probably 4 Unknown Records, Completed peen 24b. Were autopsy findings available prior to completion of cause of 24a. Was an cate has page 2 s autopsy performed? death? 2 🗌 No ∫ Yes this certificate Division of Vital 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Hospital 1 Tes 2 X No 1 Inpatient 2 ER/Outpatient 3 DOA မ 4 Nursing Home 5 Residence 28a. Date of injury (Month, Day, Year) within 24 hours free death.

To the Funeral Director: After thi completed filled in by the funeral 27. Manner of Death Certificate: 28b. Time of 28c. Injury at work? 1 □ Yes 2 □ No 28d. Describe how injury accurred injury 5 Pending **Solatural** Accident Investigation 6 Could not be Suicide 3 ☐ Suicide 4 ☐ Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one 3 29b. Signature a mpleted cause of death (Item 23a) (Typ

State

Registrar

Year)

19 201

Registrar's Signatu

11-02764 Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Crystal Bennett State of Maryland / Department of Health and Mental Hygiene 1- For State Certificate of Death Reg. No Registrar 2. Date of Death 1. Decedent's Name (First, Middle,Last) Physician/ Month Day April 11, 2011 0707 hrs Medical Examiner Crystal Lynn Bennett 4c. County of Death 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Harford 203 Bright Oaks Drive 8. Date of Birth (MM/DD/YYYY) 9. Birthplace (State or If Under 1 Year If Under 24Hrs. 6. Sex 7. Age (In yrs. last birthday) 5. Social Security Number **Funeral** Foreign 55Country) Maryland Min. Hours Months Days October 31,198 Director 25 212-11-4003 1 M Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County 1 Yes 2 X No Balto. Nottingham Baltimore, MD 21215-0036
permit. Pages I and 2 should be filed within 72 hours after death with the Maryland
Department of Health and Montal Hygien:
Important: If item 27 is marked after than "natural", nr items 23a nr 28a-f shnw
injury or other traumatic event, the Mediral Examiner must be notified at once. Md. Director 10g. Citizen of What Country? 10f, Zip Code 10e. Street and Number 4212 Penn Avenue 21236 14. Race - American Indian, Black, Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-11. Marital Status 12. Was Decedent Ever in U.S. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) White, etc. Armed Forces? 1 Never Married 2 Married 1 Yes Specify White 1 Yes 2 X No specify: Yas, Give Yaar 3 Widowed Divorced δ 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation (Give kind of work done 15. Decedent's Education (Specify only highest grade completed) Completed during most of working life. DO NOT use retired) College (1-4 or 5+) Elementary/Secondary (0-12) Giant 12th Clerk 18.Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Vicki Lynn Buettner Richard Bennett, Jr. 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Va 8835 woodlawn Way Springfield Richard Bennett 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, 20a. Method of Disposition crematory or other place) 1 X Burial 2 Cremation 3 Removal from State -16-2011 Bel Air, Md. BelAir Memorial 4 Donation 5 Other Specify. 22 Name and Address of Facility Schimunek Funeral Home 21. Signature of Funeral Service Licens Road Nottingham, Belair Approximate Interval 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart **Physician** failure. List only one cause on each line. 'Medical a Narcotic (fentanyl and oxycodone) intoxication Immediate Cause (Final disease aminer or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, Due to (or es a consequence of): if any, leading to immediate Examine cause. Enter Underlying Cause (Disease or injury that initiated Due to (or as a consequence of): events resulting in death) Last signed by the attending physician and be detached for use as the burial - transit Hospital or Attending Physician: The law requires that the death certificate be executed Physician/Medical AMENDED 23a, 27, 28a-f, per me, g916 6-14-11 sm X UNPENDED 23d. Date of delivery Box 68760 23c. If yes, outcome of pregnancy 3 Ectopic pregnancy Day Month 3b. Was decedent pregnant in the Live birth Fetal death 2 past 12 months? Pregnant at time of death 5 Other (Specify) 1 Yes 2 No 9 V Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. o Ś ο. Completed Records, 24a. Was an s peen s autopsy death? performed' certificate has 1 🕢 Yes ✓ Yes 2 No 26.Place of Death (Check only one) 25. Was case referred to medical Be Hospital: 1 Inpatient 2 DOA ER/Outpatient 3

Retween Onset and

Year

1 Yes 2 No 3 Probably 4 V Unknown 24b. Were autopsy findings available prior to completion of cause of 2 No of Vital Other Nursing Home 5 Residence 6 Other: Scene this 1 Yes 28d. Describe how injury occurred 28b. Time of Injury 28c. Injury et Work? 28a. Date of Injury (Month, Day, Year) 27. Manner of Death After Certification 1 Yes 2 X No Unknown 1 Natural Pending uneral Director: ly filled in by the f fd 4-11-11 fd 6:55 am 28f. Location (Street and Number or Rural Route Number, City or Town, State) 203 Bright Oaks Dr. Bel Air, Md. Investigation Accident 28e. Place of Injury - At home, farm, street, factory, office building, etc 3 Suicide Could not be determined To the Hospital within 24 hours at To the Funeral Completely filled (Specify) Found at home 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier 1 [2 Wedical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical one) 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier April 12, 2011 O.C.M.E. 30. Name and address of person who completed cause of death (Item 23a) 111 Penn Street, Baltimore, MD 21201 Assistant Medical Examiner Donna M. Vincenti, MD 32. Registrar's Signature 31. Date filed (Month, Day, Year) State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene, 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Year Cornelius James Cunningham 745 AM 2011 Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death FRANKLIN Square Hospital Center Ros edal Baltimore If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) March28, If Under 1 Year Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) **Funeral** 1 XM 2 F Hours Min Days 214-44-1560 Director 66 Yrs. Usual Residence of Decedent or 28a-f show notified at 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits with the Maryland Director Essex Baltimore MD 1 Yes 2 X No Cunningham 10e, Street and Number 10f. Zip Code ò 10g. Citizen of What Country? Examiner must be 21221 Funeral items 23a 404 Celeste Avenue USA 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. 10 ş 1 Never Married 2 Married 1 ☐ Yes 2 😿 No If Yes, Give Year or Dates. 5-0036 1 Yes 2 No Specify: "natural" Completed 3 Widowed 4 Divorced Specify: White Medical Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Federal 2121 than Elementary/Seconday (0-12) College (1-4 or 5+) Budget Analyst the Ith and Mental Hygien
27 is marked other to
traumatic event, the 2yrs Government Be Maryland 18. Mother's Name (First, Middle, Maiden Surname)
Rose Moore 17. Father's Name (First, Middle, Last) 2 James Cunningham 1 and 2 should be of Health and Mer 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health ar Important: If item 27 is any injury or other trauonce. Kathleen Cunningham /wife 404 Celeste Avenue Baltimore MD 21221 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other place)
Holly Hill Cemetery 4/15/1 1 Burjal 2 Cremation 3 Removal from State Baltimore MD 4 ☐ Denation 5 ☐ Other (Specify) 21. Signa 22. Name and Address of Facility 300 Balto. MD ssex 21221 Mace Ave. Connelly Funeral Home of Essex 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ Preumonia disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Aspiration syndrome Recurrent Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Cause (Disease or iinjury that initiated events resulting in death) Last Hospital or Attending Physician: The law requires that the death certificate be executed 005T-00110 burial-tran and Due to (or as a consequence of): attending physician for use as the buria Physician/Medical IF FEMALE: nse 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) in the past 12 months?
1 Yes 2 No Month Dav Year been signed by the should be detached P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has completed filled in by the funeral director, page 2 autopsy performed certificate 1 Yes 2 No Yes 25. Was case referred to medical 26. Place of Death (Check only one) a examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 🖸 No 1 🗌 Yes Certificate: To 1 Inpatient 2 ER/Outpatient 3 DOA this 27, Manner of Death 28a. Date of injury 28b. Time of 28c. Injury at To the Hospital or Attending F within 24 hours after death. To the Funeral Director: After Natural (Month, Day, Year) 5 Pending work 1 Yes 2 No ☐ Accident Investigation 6 Could not be Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Gertifying (Turse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check 3 only one) 29b. Signature and title of certifier 29c. License numbe 29d. Date signed (Month. Day, Year) 以 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Balto md 21237

Registrar DHMH 17 Rev 7/2009

として

32. Registrar's Signature

2000 FRANKLIN Square

Samiec

DR Carrie

31. Date filed (Month, Day, Year) APR 1 9 2011

11-02809 Jeffrey Cook

Please Type or Print in Black Indelible luk. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1- For State Certificate of Death Reg. No. Registrar 2. Date of Death Physician/ 1. Decedent's No Medical Examiner JEFFREY 1. Decedent's Name (First, Middle, Last) 3. Time of Death Month Day April 12, 2011 1754 hrs GRANT COOK 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death 1510 Maywood Avenue **Baltimore County** Towson If Under 1 Year If Under 24Hrs. 8. Date of Birth(MM/DD/YYYY) 9. Birthplace (State or 5. Social Security Number 7. Age (In vrs. last birthday) **Funeral** Days Hours Director 220-46-2922 1XXM 2 F 07/20/1960 50 Country Yrs Usual Residence of Decedent 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 Yes V V No Maryland Baltimore Towson with the Maryland 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country 1510 Maywood Avenue 21204 USA Funeral 11 Marital Status 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, 1)XXIVever Married 2 Married Armed Forces White, etc. NXXX. Yes Pages 1 and 2 should be filed within 72 hours after tent of Health and Mental Hygiene.
Int: If item 27 is marked other than "natural", o White 4 Divorced If Yes, Give Year or Dates: 1 Yes 2 X No specify: 2 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done 16b. Kind of Business/Industry ment of Health and Mental Hygiene.

tant: If item 27 is marked other than "natur
or other traumatic event, the Medical Exam during most of working life, DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) **Baltimore, MD 21215-0036** Litigation Attorney 17. Father's Name (First, Middle, Last) 18.Mother's Name (First, Middle, Maiden Surname) Be Walter Taylor Cook Anne Lee Bowen 19a, Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1055 West Joppa Road #601 Towson, Maryland 21204 Anne Lee Bowen Cook Huether Mother 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, 20c. Location - City or Town, State crematory or other place) XXX Burial 2 Cremation 3 Removal from State Druid Ridae Cemeterv 04/21/2011 Pikesville, Maryland 4 Donation 5 Other Specify 22. Name and Address of Facility Signature of Funeral Service Licens Mitchell-Wiedefeld Funeral Home Inc 6500 York Road Baltimore, Maryland 21212 23a. Part I. Enter the disease or complication failure. List only one cause on each line. that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or hea Approximate Interval **Physician** Between Onset and /Medical Death Cocaine, Alcohol, and Oxycodone Intoxication ≟xaminer or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause Due to (or as a consequence of): Examiner (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): and - transit Physician/Medical AMENDED 23a, 27, 28a-f per me g915 5-4-11 vt ending physician a use as the burial -X UNPENDED In the Hospital or Attending Physician: The law requires that the death certificate be Box 68760, 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant in the Month 1 Live birth 2 Fetal death 3 Ectopic pregnancy Year Day past 12 months? Pregnant at time of death 5 Other (Specify) 1 Yes 2 No 9 Unknown g Unknown the P.O. I 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <u>6</u> 1 Yes 2 No 3 Probably 4 ✓ Unknown page 2 should be Completed Division of Vital Records, certificate has been 24a. Was an 24b. Were autopsy findings available prior to completion of cause of autopsy performed? 1 ✓ Yes 2 No death? 1 🗸 Yes 2 No director. 25. Was case referred to medical 26.Place of Death (Check only one) Be examiner? Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other Nursing Home 5 Residence 6 Other Scene this 1 Yes No 28a. Date of Injury (Month, Day, Year) After 28d. Describe how injury occurred 27. Manner of Death 28b. Time of Injury 28c. Injury at Work? ___ Natural 5 Pending 1 Yes 2 X No within 24 hours after death.

To the Funeral Director: filled in by the fd 4-12-11 fd 5:45pm 2 Accident Investigation 28f. Location (Street and Number or Rural Route Number, City or Town, State) 1510 Maywood Ave. 28e. Place of Injury - At home, farm, street, factory, office building, etc. 3 Suicide 6 X Could not be determined residence 4 Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. cal 2 📝 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) O.C.M.E. April 13, 2011 ame 30. Name and address of person who completed cause of death (Item 23a)

DHMH 17 Rev 1/2001 **OCME 2006**

State Registrar

Pamela E. Southall, MD

31. Date filed (Month, Day, Year) APR 19 2011

111 Penn Street, Baltimore, MD 21201

Assistant Medical Examiner

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene.

Amend Item 19b per fh,g914,04/19/2011dbb

Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month Medical 4a. Facility Name (if not institution, give street at 4b, City, Town, or Location of Death County of Death Examiner OCKWODA 1MOrt Age (In yrs. last birthday) Date of Birth 9. Birthplace (State or Foreign **Funeral** Months Hours 1 🗆 M 2 🗹 rinidaa Director show 10a. State 10b. County City, Town or Location 10d. Inside City Limits with the Maryland notified at Director 28a-f 1 Yes 2 No HMORE 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? items 23a or ner must be n ò Funeral 21207 Page 1 and 2 should be filed within 72 hours after death 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian. Examiner Armed Forces?
1 ☐ Yes 2 ☑ No Black, White, etc. 1 Never Married 2 Married ō ğ 21215-0036 1 🔲 Yes 2 🗹 No If Yes, Give Year or Dates Specify: Specify: Blac 3 ☑ Widowed 4 ☐ Divorced Completed the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working Il Hygiene. life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Be Baltimore, Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname, h and Mental H 7 is marked ot မ hns on 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Informant's Name/Relationship (Type, Print) 3612 Lockwood Road, Balto., MD 21207 Health tem 27 ar other item 20a. Method of Disposition 20b. Place of Disposition (Name of cerpetery, crematory or other place, 20c. Location - City or Town, State permit. Page 1 a
Department of H
Important: If ite
any injury or ot 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) H more Signature of Funeral Service Licensee 22. Name and Address of Facility Vaughn G. Greens F 15t0 NA 23a. Part 1. Ent if the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or shock, or hear failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final disease or condition Onset and Death Physician/ Rueu Medical resulting in death) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or impury that initiated events Examiner Due to (or as a consequence of): Due to (or as a consequence of): resulting in death) Last the burialthe attending physician ned for use as the buria Completed by Physician/Medical or Attending Physician: The law requires that the death certificate be P.O. Box 68760 IF FEMALE: 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?

1 Yes 2 No Month Day **To the Funeral Director:** After this certificate has been signed by the sompleted filled in by the funeral director, page 2 should be detached 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? No 3 ☐ Probably 4 ☐ Unknown Division of Vital Records, 1 🗌 Yes 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed Yes 2 25. Was case referred to medical To Be 26. Place of Death (Check only one, examiner? Other: 1 🗌 Yes 2 No 4 ☐ Nursing Home 5 KResidence 6 ☐ Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 28c. Injury at s after death. 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Certificate: injury 1 🔀 Natural 5 Pending 1 Yes 2 No Accident Investigation 6 Could not be Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide City or Town, State) To the Hospital o within 24 hours aff To the Funeral Di Medical Extifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Under the cause (s) and manner as stated.

Description of the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signa 29d, Date signed (Month, Day, Year) 8215000 4/18 Name and address of person who completed cause of death (Item 23a) (Type, Print) Suite 4105, 8 a Muere

DHMH 17 Rev 7/2009

State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ 120 Chambers 4:30 AM James Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Hospital itimae Baltimore Social Security Number g. Birthplace (State or Foreign 7. Age (In yrs. last birthday) 1 Year If Under 24 Hrs 8. Date of Birth Funeral 212-30-8572 1 **⊠**M 2 □ F 8 Months Hours (Month, Day, Year, Country) Director Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mertal Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho array injury or other traumatic event, the Medical Examiner must be notified at any injury or other traumatic event, the Medical Examiner must be notified at 10a, State 10c. City, Town or Location 10d. Inside City Limits Director MD1 Yes 2 No Baltimore 10e. Street and Number 10g. Citizen of What Country? Funeral 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 Tes 2 No Specify. 3 ☐ Widowed 4 ☐ Divorced Completed Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) /Se**€**onday (0-12) College (1-4 or 5+) burer Be 18. Mother's Name (First, Middle, Maiden Surname) Jone ural Route Number, City or Town, State, Zip Code) 19b. Mailing timore mD 21229 20b. Place of Disposition cemeters cremator Method of Disposition 20c, Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State Moodlawn onD -2011 4 Donation 5 Other (Specify) 21. Si a re of Fur er I Service Licens 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Immediate Cause (Final Onset and Death Physician/ Hultifocal cucephalomalacia disease or condition Medical resulting in death) Due to (or as a consequence of) **Examiner** chemic Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Examine and Due to (or as a consequence of) resulting in death) Last Physician/Medical Physician: The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months? Day Pregnant at time of death Yes 2 No g Unknown Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Be Completed by hyperlipidaemid 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4, Wunknown 24b. Were autopsy findings available prior to completion of cause of death? 24a, Was an autopsy rmed? 1 Yes 2 No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 2 No 1 Yes Certificate: To 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28c. Injury at work?
1 \square Yes 28b. Time of 28d. Describe how injury occurred To the Hospital or Attending I within 24 hours after death.

To the Funeral Director: After 1 X Natural injury 5 Pending 2 🗌 No 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 29b. Signature and title of certifier 29c. License number Apri 17,2011 000 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Sinai Hospital of Baltimore, 2401 w Belvedore Ave, Baltimore, 40 Milikovic 31. Date filed (Month, Day, Year) APR 1 9 State

DHMH 17 Rev 7/2009

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend items 20a-c per fh g915 5-9-11 vt
State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. dent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Vear Month Day **Physician** -ind A M 0318 2011 April /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Sinai Hospital of Balhmore Balhmore Cim If Under 1 Year | If Under 24 Hrs. Months Days Hours Min. 8. Date of Birth 2 Ag, 23 -5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Days 213-64-372 Months 1 □ M 2 🔀 F 55 Director Usual Residence of Decedent 10d. Inside City Limits 10a. State 10b. County 10c. City. Town or Location 28a-f show Injury or other traumatic event, the Medical Examiner must be notified at 1 **M**es 2 □ No Director MDtimore 10e. Street and Nup Be 10g. Citizen of What Country? 10f. Zip Code ò death with 21207 *tarkview* 23a Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 No 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, or items 11. Marital Status Black, White, etc. 1 ☐ Yes 2 If Yes, Give Year or Dates: 1 Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: þ 3 Widowed 4 Divorced Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", any injury or other traumatic event, the Madical Exa Joan Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) as (First, Middle, Maiden Surname, 18. Mother's Name Pather's Name (First, Middle, Last) Be aloria KNOWN ပ or Rural Route Number, City or Town, State, Zip Code) 19b. Mailing Address (Street and Number 1 and 2 Health 21215 pauto 20a. Method of Disposition Pages 1 nent of F ahent Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final 1 day Awternal failure **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner 7 days Dehydrahon Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last Due to (or as a consequence of). Examine be executed and burial-tran Due to (or as a consequence of): Box 68760. attending physician Physician/Medical Hospital or Attending Physician: The law requires that the death certificate the as IF FEMALE: nse 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 🗆 Ectopic pregnancy ģ in the past 12 months? Month Day Year 5 ☐ Other (specify) P.O. the detached 9 Unknown 9 Unknown ģ signed I 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records. ò 2.☐No 3 ☐ Probably 4 ☐ Unknown 1 ☐ Yes Completed been s page 2 should 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an has autopsy certificate 1 ☐ Yes 2 ☐ No 25. Was case referred to medical examiner? director, 26. Place of Death (Check only one) Be Hospital Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2₽No 1/Inpatient 2 ER/Outpatient 3 DOA After this Certification: To funeral 27. Manner of Death Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending investigation Injury death. 1 ☐ Yes 2 ☐ No 2 Accident 24 hours after death Funeral Director: 3 Suicide 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical completely (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. the the within 7 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) Ceulia y slivi - Tamashio April 15,2011 Res 000 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) cecua Yshii - tamashiro MD 2401 W Beliedere me, Balmore MP -31. Date filed (Month, Day, Year, 2: Registrar's Signature State arker APR 19 2011 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death April Physician/ 2011 2011 P. Eloise Collingwood 8:43 Α Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Anne Arundel Medical Center Annapolis Anne Arundel Social Security Number 6. Sex 1 □ M 2**X** F If Under 1 Year If Under 24 Hrs. 8. Date of Birth Month, Day, Year) Mar 6, 1958 Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Months Hours Min. Country) Kansas Director 026-48-3429 53 Usual Residence of Decedent 28a-f shov 1 and 2 should be filed within 72 hours after death with the Maryland of Health and Mental Hygiene.
item 27 is marked other than "natural", or items 23a or 28a-f shor other traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits rector 1 Yes 2X No Maryland Anne Arundel Annapolis ۵ 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral <u> 2063 Maidstone Farm Road</u> 21409 United States Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces?

1 Yes 2 No Black, White, etc. 1 Never Married 2 Married þ Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ▼ No Specify: Specify: White 3 Widowed 4 Divorced Completed Year or Dates Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) 4 Producer Television Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ George Harris Collingwood Mary Elizabeth Wroth 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 sh Department of Health ar Important: If item 27 is any injury or other trau Marjorie Kimble / Sister Cumberland Ct., Annapolis, Maryland 21401 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 04/18/2011 Baltimore, Maryland Metro Crematory Inc. 21. Signature of Funeral Service Licensee Alyson K Taylor 22. Name and Address of Facility Cremation Society of Maryland 299 Frederick Rd., Baltimore, Maryland 21228 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onse and Death shock, or heart failure. List only one cause on each line Immediate Cause (Final disease or condition Stroke Pnysician/ Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of): Cause (Disease or linjury that initiated events Exal -tran and Due to (or as a consequence of): resulting in death) Last attending physician a for use as the burial-Physician/Medical or Attending Physician: The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) ____ in the past 12 months?

1 Yes 2 No Day Pregnant at time of death ed by the a detached f 9 Unknown 9 Unknown s been signed by should be deta Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an autopsy performed? Yes 2 N this certificate has ral director, page 2 2 🗌 No 1 Tes 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 **N**No 1 🗌 Yes မ 1 Npatient 2 ER/Outpatient 3 DOA within 24 hours after death.

To the Funeral Director: After the completed filled in by the funeral 27. Manner of Death 28a. Date of injury 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred (Month, Day, Year) Natural work? 1 ☐ Yes 2 ☐ No 5 Pending M Accident Investigation 3 ☐ Suicide 4 ☐ Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined To the Hospital Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a Certifier 3 🗆 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) meral Bah, MD D 46052 4117111

DHMH 17 Rev 7/2009

State

Registrar

31. Date filed (Month, Day, Year)

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ank

annapolis, Mb

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

The Bulk Typ 2000 Weelical Pouhway

Registrar's Signatur

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Anni 16 201 0040AM REVEKA DEYCH Medical 4a. Facility Name (if not institution, give street and number **E**xaminer 4b. City, Town, or Location of Death 4c. County of Death Hospital of Baltimone Baltimor N/A Social Security Numbe 6. Sex If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) Funeral 8. Date of Birth Birthplace (State or Foreign Country) 1 □ M 2 🗓 F 07/27/1945 Director 212-27-0626 65 Yrs. RUSSIA Usual Residence of Decedent show 10a. State with the Maryland "natural", or items 23a or 28a-f sho i ifical Examiner must be notified at 10c, City, Town or Location 10d. Inside City Limits Director 1 X Yes 2 No MD N/ABALTIMORE 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? Funeral 6970 MARSUE DRIVE, #2C 21215 USA 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No
If Yes, Give 11. Marital Status 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 1 Never Married 2 X Married Completed by Baltimore, Maryland 21215-0036 filed within 72 hours after 1 🗆 Yes 2 🔀 No 3 Widowed 4 Divorced WHITE Year or Dates 15. Decedent's Education 16a Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) nd Mental Hygiene. marked other than Elementary/Seconday (0-12) College (1-4 or 5+) 12 TYPIST JOURNALISM permit. Page 1 and 2 should be filed Department of Health and Mental Hyg Important: If item 27 is marked any injury or other transcences. Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ROSENWASSER CHERNA LEIBOUNA 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) NIKOLAY DEYCH / SON PRECOURT LANE, NORTON, MA 02766 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) BALTIMORE HEBREW 04/18/2011 REISTERSTOWN, MD 21. Signature of Funeral Service Lie 22. Name and Address of Facility SOL LEVINSON & BROS., INC. 8900 REISTERSTOWN ROAD, PIKESVILLE, MD 21208 23a. Part Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line Interval Between Immediate Cause (Final Onset and Death Physician/ Metastatic renal cell carcinoma disease or condition resulting in death) 2009 to 100 , Medical Examiner Due to (or as a consequence of). Sequentially list conditions, Examiner if any leading to immedicause. Enter Underlying Cause (Disease or linjury that initiated events resulting in death) Last been signed by the attending physician and should be detached for use as the burial-tran Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?

1 Yes 2 No Month Pregnant at time of death 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ abrill ation 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 X Unknown Completed Were autopsy findings available prior to completion of cause of 24a. Was an 1 Yes 2 No Yes To the Hospital or Attending Physician: I within 24 hours after death.

To the Funeral Director: After this certifics completed filled in by the funeral director; I 25. Was case referred to medical Be 26. Place of Death (Check only one) 1 ☐ Yes 2 🛣 No Other: ၉ 1X Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 X Natural iniury work? 5 Pending 2 🗆 No 2 Accident
3 Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined Medical 29a. Certifier 1 🔀 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practice To the basis of my hippersonal death occurred at the time, date and place and due to the cause(s) and manner as stated. (Check 29d. Date signed (Month, Day, Year)
April 16,2011 -, HD D66130 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) SINA; HOSPITAL OF BALTIMORE, 2401 W Belveder the 21215 ANA EMILIAND, MD

DHMH 17 Rev 7/2009

Registrar

31. Date filed (Month, Day, Year)

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2437 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month April Physician/ 11 2011 Roslyn Lauretta Davis 8:26 P. Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death Joseph Richey Hospice Baltimore Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign Funeral 1 □ M 2 🗶 Hours Country)
Mary Land Director 216-28-4066 76 25 1934 Usual Residence of Decedent ral", or items 23a or 28a-f show Examiner must be notified at 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits 72 hours after death with the Maryland Director 1X Yes 2 ☐ No Maryland N/A Baltimore 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? Funeral 3948 Dolfield Avenue 21215 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status 14. Race - American Indian. Black, White, etc. "natural", or þ 1 Never Married 2 Married 1 ☐ Yes If Yes, Give 2 X No Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: 3 Widowed 4 Divorced Specify: Black Completed Year or Dates the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) other than Tete A Tete Hair Salon Elementary/Seconday (0-12) College (1-4 or 5+) should be filed within and Mental Hygiene. 12th grade Licensed Cosmelotogist 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) marked (Robert Davis Mable Bolden permit. Page 1 and 2 should Department of Health and Mi Important: If item 27 is mari any injury or other traumati 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <u> Isaac A. Phifer/ Son</u> 3948 Dolfield Avenue Baltimore, MD 21215 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 🔀 Burial 2 🗌 Cremation 3 🔲 Removal from State 4 Donation 5 Other (Specify) Cedar Hill Cemetery 4-18-2011 Brooklyn,MD Signature of runeral Service License 22. Name and Address of Facility Chatman-Harris Funeral Home cuis 5240 Reisterstown Road Baltimore, MD 21215 23a. Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, enock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician CARCINOMA disease or condition resulting in death) 2 years Due to (or as a sequence of): Medical Examiner GASTRIC 2 years CARCINOMA Sequentially list conditions. Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence oi) for use as the burial-tran that initiated events Due to (or as a consequence of) resulting in death) Last the attending physician Physician/Medical requires that the death certificate be IF FEMALE 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day Year Pregnant at time of death 5 Other (specify) 4 ☐ Pregnant 9 ☐ Unknown detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by signe I be c Hyperlip.demiA Records, 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a. Was an page 2 Hospital or Attending Physician: The After this certificate 25. Was case referred to medical examiner? Division of Vital funeral director, Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2× No Hospital: 1 Yes 욘 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at work?
1 Yes 2 No Certificate: 28d. Describe how injury occurred injury Natural 5 Pending Accident Investigation 24 hours after deatl Funeral Director: 3 Suicide 4 Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number. filled in by determined Medical Ecertifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Numer Practioner: To the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check within 2 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 04 13 2011 H0062554 Richey 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Joseph Hospice Shen. D.0. Cynthia 838 N. EVTAN 21201 BALT. More 32. Registrar's Signature 31. Date filed (Month, Day, Year) Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month April Physician/ Flizabeth Donaldson 2:00PM 17 2011 Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Seasons Hospice Baltimore Randallstown If Under 1 Year If Under 24 Hrs. 8. Date of Birth Months Days Hours Min. Sep. 6, Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** 1 □ M 2XXF Year 923 Maryland 217-16-5822 87 Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director MD Baltimore XX Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 6401 Loch Raven Blvd. Apt. 740 21239 U.S.A. 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Forces?

1 Yes XXNo
If Yes, Give
Year or Dates. Black, White, etc. ģ ☐ Never Married 2 ☐ Married 1 ☐ Yes XXNo Specify: White Completed XX Widowed 4 Divorced 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done of life. DO NOT use retired) during most of working Elementary/Seconday (0-12) College (1-4 or 5+) 12 Supervisor Restaurant Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ W. Frank Gilbert, Sr. Eva M. Benner 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Robert B. Ackerman / Son 911 Shirley Manor Rd. Reisterstown, MD 21136 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other place, AII Faiths 1 Burial XXCremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 4/18/11 Crematory & Chapel Manchester, MD Signature d Ful eral Pervice Licens 22. Name and Address of Facility Eckhardt Funeral Chapel P.A. 11605 Reisterstown Rd. Owings Mills,MD21117 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death End-Stage (ardiom Japa They Examiner

Physician/ -Medical Examiner

physician

The law requires that the death certificate be

or Attending Physician:

Division of Vital Records, P.O. Box 68760

Director

notified 28a-f

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ms 23a or must be r

the Maryland

-transit Physician/Medical signed by t Completed by Be မ Certificate: ours after death neral Director: A filled in by the f

resulting in death)	Due to (or as a consequence of):		
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events	b. ————————————————————————————————————		
resulting in death) Last	Due to (or as a consequence of):		
IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown	3c. If yes, outcome of pregnancy 1 ☐ Live Birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy 4 ☐ Pregnant at time of death 5 ☐ Other (specify) 9 ☐ Unknown		23d. Date of delivery Month Day Year
Part II. Other significant conditions cor	ntributing to death but not resulting in the underlying cause given in Part I.		use contribute to the cause of death?
		24a. Was an autopsy performed?	24b. Were autopsy findings available prior to completion of cause of death? No 1 Yes 2 No
25. Was case referred to medical examiner?	26. Place of Death (Che	ck only one)	
1 Yes 2 No	ospital: 1 \square Inpatient 2 \square ER/Outpatient 3 \square DOA Other: 4 \square Nursing F	lome 5 ☐ Residence	6 Other (Specify)
27. Manner of Death 1 Natural 5 Pending 2 Accident Investigation 3 Suicide 6 Could not be	28a. Date of injury (Month, Day, Year) 28b. Time of injury 28c. Injury at work? 1 □ Yes 2 □ No	28d. Describe how inju	ury occurred
4 Homicide determined	28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	28f. Location (Street a City or Town, Stat	nd Number or Rural Route Number, e)
(Check 2 L Medical Examine	cian: To the best of my knowledge, death occured at the time, date and place, a er: On the basis of examination and/or investigation, in my opinion, death occurred Practioner: To the best of my knowledge, death occurred at the time, date and place.	at the time, date and place	e, and due to the cause(s) and manner stated

29c. License number

D0057-465

29d. Date signed (Month, Day, Year)

4/17/11

Baltimore, MD. 21209

DHMH 17 Rev 7/2009

State

Registrar

within 24 hours a

To the Funeral C

completed filled

Medical

29b. Signature and title of certifier

31. Date filed (Month, Day, Year)

USRajapahrem.D

5 Rajapakse MD

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

2835 Smith on

2. Registrar's Signature

arked

Please Type or Print in Black Indelible Ink, Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ 5:25 VNMVDVI Medical Facility Name (if not institution, give street and number) City, Town, or Location of Death 4c. County of Death **Examiner** last birthday If Under 24 Hrs. 9. Birthplace (State or Foreign Date of Birth **Funeral** Min Director Usual Residence of Decedent 10a. State 10b. County 10d. Inside City Limits filed within 72 hours after death with the Maryland 10c. City, Town or Location Funeral Director notified 28a-f timore 1 Yes 2 No and Number 10g. Citizen of What Country? permit. Page 1 and 2 should be filed within 72 hours after death with the Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or any injury or other traumatic event, the Medical Examiner must be a once. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12 Was Decedent Ever in U.S. Race - American Indian, Armed Forces?

Yes 2 No
f Yes, Give Black, White, etc. þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes No Specify. lac 3 Widowed 4 Divorced Completed Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working (Specify only highest grade completed) life. DO NOT use retire College (1-4 or 5+) Be ၉ 19b. Mailing Address (Street and Number or Rural Route No Johnsta 20a. Method of Disposition 20b Place of Disposition (Name of N⊈ Burial 2 ☐ Cremation 4 ☐ Donation 5 ☐ Other (Specify) 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and De th Immediate Cause (Final Physician/ Consestive Heart Failure disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Examine Due to (or as a consequence of): the burial-transit Due to (or as a consequence of): resulting in death) Last To the Funeral Director: After this certificate has been signed by the attending physician completed filled in by the funeral director, page 2 should be detached for use as the burial Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?
1 ☐ Yes 2 ☐ No Day Year Pregnant at time of death Unknown Month 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? à Atrial fibrillation 1 ☐ Yes 2 ☐ No 3 ⚠ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 2 X N Yes To the Hospital or Attending Physician: Be 25. Was case referred to medical 26. Place of Death (Check only one) 2 No Other: 1 Yes 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred work?
1 Yes 2 No 1 Natural 5 Pending injury death. Accident Suicide Investigation Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide City or Town, State) within 24 hours a Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check 29b. Signature and title of certifie 29d. Date signed (Month, Day, Year) MD 30. Name and address of person who completed cause of death (Item 23a) (Type, Print ORTH GREENEST Baltimure, M.D 21201 Amy Hwang 31. Date filed (Month, Day, Year) 32. Registrar's Signature State 9 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No 1. Decedent's Name (First, Middle, Last, 2. Date of Death 3. Time of Death Physician/ Month Davis Lee 4:50AM 2011 Medical **Examiner** 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Gilchrist HOSPICE Towson Baltimore Social Security Number If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) **Funeral** 7. Age (In yrs. last birthday) 8. Date of Birth 1 M 2 X F Months Hours (Month, Day, Year) **Director** Usual Residence of Decedent 28a-f shov 10a. State 10b. County notified at 10c. City, Town or Location 10d. Inside City Limits Director MD Baltimore Baltimore 1 Yes 2 No 10e. Street and Numbe ō 10f. Zip Code 10g. Citizen of What Country? iral", or items 23a or Examiner must be Funeral 3403 Flannen 21207 ane USA 11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. þ 1 Never Married 2 Married 1 ☐ Yes 2 No If Yes, Give Year or Dates. Baltimore, Maryland 21215-0036 item 27 is marked other than "natural", other traumatic event, the Medical Exar 1 ☐ Yes 2 XNo Specify. Specify: Black Completed 3 ₩Widowed 4 □ Divorced 15. Decedent's Education 16a, Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Baltimore County Public Schools permit. Page 1 and 2 should be filed within 7 Department of Health and Mental Hygiene. Important: If item 27 is marked other than any injury or other trainmast. Elementary/Seconday (0-12) College (1-4 or 5+) Food Service Laborer 12th grade Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ဂ္ Parne Sophiel Gibson Canty 19a. Informant's Name/Relations ip (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Clyde Divis 2123 Holder Avenue Baltimore MD 21207 20b. Place of Disposition (Name of cemetery, crematory or other place 20a. Method of Disposition 20c. Location - City or Town, State Date 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State Woodlawn, MD 04123 2011 4 ☐ Donation 5 ☐ Other (Specify) Joodlawn Cemeten 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Vangin Citreene Funcial services Randallstown MD 21133 23a. Part 1. Enter the sease, or complications that caused the deat... Do not enter the mode of dying, such as cardiac or respiratory arrest Approximate Interval Between Onset and Death shock, or heart fa lure. List only one cause on each line. Immediate Cause (Final Ph_sician/ disease or condition resulting in death) Medical **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury that initiated events Due to (or as a consequence of) Exami and -transit Hospital or Attending Physician: The law requires that the death certificate be executed resulting in death) Last Due to (or as a consequence of) burial physician s the burial Physician/Medical Division of Vital Records, P.O. Box 68760 attending p for use as t IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?

1 Yes 2 No
9 Unknown 3 Ectopic pregnancy
5 Other (specify) Year Pregnant at time of death Day ed by the a detached f Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? b Completed 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 No page 2 certificate has 1 Yes 2 No the funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) 2**X** No Hospital Other: 1 Yes ၉ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Nother (Spec After this 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending after death. 1 Yes 2 No Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, completed filled in by 4 Homicide determined 24 hours Medical 29a. Certifier 🗶 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated within 2 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. nly one Signature 29c. License number 18211000 Name and address of person who completed cause of death (Item 23a) (Type, Print) . Suite 4105, Baltinene, Mo 21204

DHMH 17 Rev 7/2009

State Registrar MIOSC

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene_ For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month A Day 3 Physician/ Demulo 20/1 Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death 6H dumbia Howard Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Feb. 20 **Funeral** 6. Sex 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign Days Hours Min. 1 🗆 M 2 🔀 F 193-14-3176 Pennsylvania 87 1924 Director Yrs. Usual Residence of Decedent 10b. County 10c. City, Town or Location with the Maryland 10d. Inside City Limits Director be notified 28a-f 1 ☐ Yes 2 🎽 No Maryland Harford Edgewood 10e. Street and Number 10f. Zip Code ò 10g. Citizen of What Country? ms 23a omnust be Funeral 616 Silver Bell Drive 21040 USA and 2 should be filed within 72 hours after death 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☎ No 14 Race - American Indian Black, White, etc. ō Completed by 1 Never Married 2 Married Yes 2 Baltimore, Maryland 21215-0036 1 Yes 2X No Specify: 3 X Widowed 4 Divorced White Year or Dates ed other than "natu event, the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life, DO NOT use retired) (Specify only highest grade completed) Elementary/Seconday (0-12) 12 College (1-4 or 5+) Mental Hygiene. Homemaker Own Home Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 27 is marked or traumatic eve ည Alexander (nmn) Vroblesky Mary (nmn) Rybarczyk 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Health em 27 Donna M. Call/ Daughter 3626 Grosvenor Dr., Ellicott City, MD 21042 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Department of H Important: If ite any injury or ot 1 Burial 2 ☐ Cremation 3 ☐ Removal from State cemetery, crematory or other place) 4 ☐ Donation 5 ☐ Other (Specify) Air Memorial Gdn 4-18-11 Bel Air, Maryland 21. Signature of Joperal Service Licensee 22. Name and Address of Facility McComas Funeral Home, P.A. 1317 Cokesbury Road, Abingdon, Maryland 21009 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Immediate Cause (Final Onset and Death Physician/ XUCa, XL4 disease or condition Medical resulting in death) Examiner Sequentially list conditions Physician/Medical Examiner if any, leading to immediate cause. Enter Underlying iabetes Cause (Disease or iinjury that initiated events resulting in death) Last attending physician and for use as the burial-transi Due to (or as a consequence of) Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?

1 Yes 2 No Month Pregnant at time of death signed by the a d be detached f 9 Unknown 9 Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🔀 Unknown page 2 should peen . Were autopsy findings available prior to completion of cause of 24a. Was an has autopsy death? within 24 hours after death.

To the Funeral Director: After this certificate I completed filled in by the funeral director, page Yes 2 No 1 Yes 2 No Division of Vital 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital 2 No Other: မှ 1 Yes 1 Inpatient 2 FR/Outpatient 3 IDOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify, 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred Hospital or Attending 24 hours after death. 1 Natural 5 Pending iniury work? 1 ☐ Yes 2 ☐ No 2 Accident
3 Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number 4 Homicide determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 29d. Date signed (Month, Day, Year) 0002フフ/ 20/1 30. Name and address of person who mpleted cause of death (Item 23a) (Type, Print) Columbia Marxlan MD 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month 04 Physician/ 2011 7:58 Α Disney Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (if not institution, give street and number) Examiner Anne Arundel Glen Burnie Baltimore Annapolis Blvd. 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign 6. Sex 1 ☐ M 2 🛛 F Social Security Number **Funeral** Months Days Hours Min. 96 Yrs. 06/21/1914 **Director** 214-62-1865 Usual Residence of Decedent 10d. Inside City Limits 28a-f show 10c. City, Town or Location 10a. State 10b. County item 27 is marked other than "natural", or items 23a or 28a-f sho other traumatic event, the Medical Examiner must be notified at Page 1 and 2 should be filed within 72 hours after death with the Maryland Director 1 🗌 Yes 2 🌠 No Glen Burnie MD Anne Arundel 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number Funeral U.S.A. 21060 7541 Baltimore Annapolis Blvd. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 12. Was Decedent Ever in U.S. Black, White, etc. Armed Force þ 1 Never Married 2 Married 1 Yes 2 No If Yes, Give Baltimore, Maryland 21215-0036 1 Yes 2 No Specify. Specify: White 3 X Widowed 4 ☐ Divorced Completed Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry 15. Decedent's Education (Specify only highest grade completed) of Health and Mental Hygiene. item 27 is marked other than Elementary/Seconday (0-12) College (1-4 or 5+) Own Home Homemaker Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) ပ္ Duva11 Nellie William 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Pinehurst, NC 28374 285 Inverrary Road Mrs. Jill Fleisher / Niece 20b. Place of Disposition (Name of cemetery, crematory or other place, 20c. Location - City or Town, State 20a. Method of Disposition permit. Page 1 a Department of H Important: If ite any injury or ot 1 🔀 Burial 2 🗌 Cremation 3 🗎 Removal from State Glen Haven Mem. Park 04/20/2011 Glen Burnie, MD 4 Donation 5 Other (Specify) 22. Name and Address of Facility 1 2nd Avenue SW Glen Burnie, MD Signature Funeral Se Singleton_Funeral & Cremation Services, PA or call plications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest Interval Between shock, or heart failure. Lin Onset and Death be disen Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner sequentially list conditions. Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury Due to (or as a consequence of): ementio the burial-transit Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events Due to (or as a consequence of): resulting in death) Last nding physician Physician/Medical Box 68760 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 Unknown 9 Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? þ we Venon 1 Tes 2 No 3 Probably 4 Unknown Division of Vital Records, Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an performed Yes 24 No 1 ☐ Yes 2 ☐ No 26. Place of Death (Check only one) 25. Was case referred to meetical Be examiner? Hospital 1 Tyes 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 27. Manner of Death Certificate: 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No Investigation Accident 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) within 24 hours after de To the Funeral Directo completed filled in by th 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 2011 325 Hoogntal 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Gien SAWHNERY 32. Registrar's Signature 31. Date filed (Month, Day, Year) State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Amend Item 2 State of Maryland / Department of Health and Mental Hygiene Th, 8914,04/28/2011dhb 1 - For State Registrar 2011 12443 Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Louis C. Eifert, Jr. Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City. Town, or Location of Death County of Death timore If Under 1 Year | If Under 24 Hrs.
Months | Days | Hours | Min. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 **X** M 2 □ F Months Days 212-30-0061 Country) 82 09/19/1928 Director MD' Usual Residence of Decedent or 28a-f show a notified at 10a, State 10h Count 10c. City, Town or Location Parkville 10d. Inside City Limits within 72 hours after death with the Maryland Director Baltimore MD 1 Yes 2 No 10e. Street and Number ò 10f. Zip Code ,15 23a o₁ 10g. Citizen of What Country? Funeral United States 2459 Woodcroft Road 21234 items "natural", or item ledical Examiner n Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces?

1 X Yes 2 No
If Yes, Give Black, White, etc. þ 1 Never Married 2 X Married Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: White 3 Divorced 4 Divorced Completed Year or Dates traumatic event, the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16h Kind of Business Industry (Specify only highest grade completed) 2 should be filed within 72... h and Mental Hygiene. 7 is marked other than "r Elementary/Seconday (0-12) College (1-4 or 5+) Auto Body & Fender Technician Miller Buick Be 17. Father's Name (First, Middle, Last) Mother's Name (First, Middle, Maiden Sumame) **Pauline Gebhardt** ျှ Louis C. Eifert, Sr. 1 and 2 should but Health and Meitem 27 is mark 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mary Ellen Eifert - Spouse 2459 Woodcroft Road, Parkville, MD 21234 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State permit. Page 1 a
Department of IImportant: If ite
any injury or ot 04/18/2011 cemetery, crematory or other place) ☐ Burial 2 X Cremation 3 ☐ Removal from State Forest Hill, MD 4 Donation 5 Other (Specify) Evans Funeral Chapel Belair 22. Name and Address of Eacility Evans Funeral Chapel & Cremation Services-Parkville, 8800 Harford Road, Parkville, MD 21234 . Signature of Funeral Service Licensee Tiffany Cohn per DVR 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final disease or condition Onset and Death Ph sician/ Medical resulting in death) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events resulting in death) Last Examiner Due to (or as a consequence of): sician and burial-transit To the Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of): attending physician Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: f yes, outcome of pregnancy

Live Birth 2 Fetal death 3 Ectopic pregnancy

Second at time of death 5 Other (specify) 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months? Month Day 1 ☐ Yes 2 ☐ 9 ☐ Unknown the g Unknown cate has been signed by page 2 should be detac Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 2 No 3 Probably 4 Unknown Completed 1 🗌 Yes 24a. Was an Were autopsy findings available prior to completion of cause of autopsy performed? Yes 2 No death? Director: After this certificate 25. Was case referred to medical Certificate: To Be 26. Place of Death (Check only one) examiner? Hospital: Other: 2 💢 No 4 Nursing Home 5 Residence 6 Other (Specify, 1 XInpatient 2 - ER/Outpatient 3 - DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred Natural 5 Pending injury 1 ☐ Yes 2 ☐ No Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined within 24 hours after To the Funeral Direct 1 🔀 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 20-2011 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 1601

State

Registrar

(Month, Day, Year)

APR 28

			For	Pleas	se Type or F State of									_	le.		
			State Registrar	To a best of	(4)		Ce	rtifica	ate of L	Death			Reg. N	.201		121	, 4 4
	siciar edica	al .	1. Decedent's Name JAMES ERF	IARDT								2. Date of D		2 ^y , 2ŏ	11	3. Time of E	
Exa	ımine	er	4a. Facility Name (if 7927 WYN		give street and numbe	er)		4b. C	ity, Town, or EAS	Location of CWOOD	of Death		40	BALTI		2	
Fund Direct			5. Social Security No.	umber (Age (In yrs. I	last birthday) Yrs.	If Un Month	der 1 Year	If Under Hours	24 Hrs. Min.	8. Date of Bi		9		ace (State or	Foreign
land	ar	_ h	Usual Residence of 10a. State				ty, Town or L	ocation							10	ld. Inside City	Limits
Maryla 28a-f s	omied	Director	MD.	BALTI	MORE		EASTWO	OD								1 🗌 Yes	
with the	at pe u	ralD	10e. Street and Num 7927 WYN		en.			10f.	Zip Code	,	21224			itizen of Wha			
re, Maryland 21215-0036 1 and 2 should be filed within 72 hours after death with the Maryland if Health and Mental Hygiene. Item 27 is marked other than "natural", or items 23a or 28a-f sho	-Xammer mu	ğ	11. Marital Status 1 Never Marri 3 Widowed	ied 2 🗆 Marrie	12. Was Decede Armed Force 1 XYes 2 If Yes, Give	es? □ No 19		If Yes, s	cedent of Hi decify Cuba	ispanic Oriç ın, Mexican	gin? (Spec	ify Yes or No	_	14. Race - , Black, \		n Indian, tc.	
5-00 2 hours "natur	dical i	plete		15. Decedent	Year or Date 's Education t grade completed)	s. 19	16a. Dece	dent's U	sual Occup vork done c	ation	of warkin	2	16b. I	Kind of Busin			
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Maryland 21215-0036 2 should be filed within 72 hours after th and Mental Hygiene. 27 is marked other than "natural", o	l lanc	-	ARTHUR E		o (Type, Print)		19b Mail	ing Addr	ess (Street :			AGNES				nde)	
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Baltimore, permit. Page 1 and Department of Hea Important: If item	5 5		20a. Method of Disp 1 ፟፟X Burial 2 4 ☐ Donation	Cremation 3	B ☐ Removal from St	ate	Place of Disp cemetery, cre WNSVII	matory o	r other plac		D: 4/15/	ate 2011	l .	ocation - Cit	-	vn, State MARYI	LAND
Balti permit. I Departn Importa	once.	İ	21. Signature of Fur						and Addres	s of Facility	y CHA	RLES S	5. Z		AND	SON,	
		+	23 Part . Herti	e disease, or c	omplications that cau	ised the deat								1, III		Approximate	
Physici Med	_		Immediate Cause (I disease or condition resulting in death)	Final	_a_ acv	ute n	Moca	rdio	d ir	Farc	tion	2				Interval Betwoonset and De	
Examí	ner				Due to (or	as a consequ	uen e of):										
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Division of Vital Records, P.O. Box 68760 Hospital or Attending Physician: The law requires that the death certificate be executed Funeral Director: After this certificate has been signed by the attending physician and shed filled in by the intended director, have 2 should be deschool for use as the burial-transit			F FEMALE: 23b. Was decedent in the past 12 n 1 Yes 2 9 Unknown	nonths?	23c. If yes, outco 1 ☐ Live Bir 4 ☐ Pregnal 9 ☐ Unknov	th 2 🗌 Feta nt at time of c	al death 3	☐ Ectopi ☐ Other	c pregnanc (specify)	у				23d. Date o Month		y Day Ye	ar
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of Vi		2	1 ☐ Yes 2 🔀 27. Manner of Death	1 No	1 🗌 Ing	oatient 2 🗆 injury	ER/Outpatie	_	DOA Othe	4 ⊔ Nu		ne 5 Resi			Specify)		
Jivision of Vital Rec lor Attending Physician: The la after death. Director: After this certificate he Lin by the fineral director page	Totografic	ll Car	1 ☑ Natural 2 ☐ Accident 3 ☐ Suicide	5 ☐ Pending Investiga 6 ☐ Could no	tion	Day, Year)	injury	М	work	? Yes 2 🗆	- 1			,			
Division of Vital Records, ital or Attending Physician: The law requires are derector. After this certificate has been signal by the fineral director, range 2 should be led in by the fineral director range 2 should be			4 Homicide	determine	ed 28e. Place of building,	etc. (Specify					Ų	8f. Location (City or Tox	vn, State)			s
To the Hospital of within 24 hours at to the Funeral Dominished filled in	200	Medical	(Check 2	Medical Exa	hysician: To the best aminer: On the basis of arse Practioner: To	of examination	and/or inves	tigation.	n my opinio	n, death occ	curred at the	ne time date :	and place	and due to	the caus	e(s) and mann	ner stated.
To the I within 2 To the I complex			9b. Signature and ti	itle of certifier				2	9c. License	number				te signed (M	lonth, Da	ay, Year)	
			Name and address	V 1 C	o completed cause of		23a) (Type		Dod	155	157		F	tpr	14,	2011	
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	State strar	_	APR 19	2011 ear)	32. Re	strar's Super	Kel										

Please Type or Print in Black Indelible Ink 15 State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death dent's Name (First, Middle, Last) 2 Date Month Date of Death Time of Death **Physician** /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give stre Examiner Johns Hopkins Bayview Medical Center N/A**Baltimore** If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In yrs, last birthday) **Funeral** 1 💢 M 2 🗆 F 94 410-05-6394 FEB. 17, 1917 Director Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County at XX Yes 2 □ No Director BALTIMORE MD. N/A ral", or Items 23a or 28a-f s Examiner must be notified 10e. Street and Number 10f. Zip-Code 10g. Citizen of What Country? 21224 UNITED STATES 415 FOLCROFT ST. Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces?
1 ☐ Yes 2 ☑ No 11. Marital Status Black, White, etc. 1 Never Married 2 Married 21215-0036 1 ☐ Yes 2 🙀 No Specify \$ If Yes, Give Specify: WHITE 3 Widowed 4 Divorced Year or Dates: "natural", Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education Medical (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) GLENN L. MARTINS SUPERVISOR the other 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last, Baltimore, Maryland Be th and Mental F 7 is marked ot traumatic even MARTHA JANE RUSH WILLIE LESTER FOX ည 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) of Health a 21224 415 FOLCROFT ST., BALTIMORE, MARYLAND VERA FOX/WIFE item 2 20a. Method of Disposition
1X Burial 2 ☐ Cremation 3 ☐ Removal from State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 04/2072011 Department of Important: if any injury or once. **=** 5 4/19/2011 | WAYNE, WEST VIRGINIA 4 ☐ Donation 5 ☐ Other (Specify) EVERETT ADKINS CEM. 21. Signature of Funeral Service License 22. Name and Address of Facility CHARLES S. ZEILER & SON, INC. 21224 6224 EASTERN AVE., BALTIMORE, MARYLAND 1 Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or to particular that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure s my Immediate Cause (Final disease or condition resulting in death) one caus n each line **Physician** /Medical **Examiner** Sequentially list conditions, if any, leading to him ediate cause. Enter Underlying Cause (Disease or injury Examine Due to for sein consequence of or Attending Physician: The law requires that the death certificate be executed physician and that initiated events resulting in death) Last Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, Physician/Medical attending p IF FEMALE: 23b. Was decedent pregnant 23d. Date of delivery 1 Live birth 2 Fetal death 4 Pregnant at time of death 3 Ectopic pregnancy in the past 12 months? Month Day Year 5 Other (specify) ed by the at detached f 2 No 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? \$ 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy has performed? 2 No 2 No certificate 25. Was case referred to medica Be 26. Place of Death (Check only one) Hospital: 1 Inpatient Other: 4 \square Nursing Home 5 \square Residence 6 \square Other (Specify) 2 🗆 No ER/Outpatient 3 DOA Yes မ this 28a. Date of Injury 8b. Time of 28d. Describe how injury occurred or of Death 28c. Injury at Work? Certification: (Month, Day atural Ac-dent 5 Pending investigation М 1 ☐ Yes 2 ☐ No neral Director: A after death 6 ☐ Could not be 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined 4 Homicide City or Town, State) within 24 hours a

To the Funeral D

completely filled the Hospital Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical (check only ical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Date signed (Month. Dav. Year) 29b. Signature and title of certifier 4940 Eastern Avenue, Baltimore, MD, 21224 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar DHMH 17 Rev 1/2001

ORIGINAL

11595

State of Maryland / Department of Health and Mental Hygiene-Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ April 2011 PATRICIA VIRGINIA **FAUCETT** 9:15 рМ Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death **Examiner** Sacred Heart Nursing Home Hyattsville Prince George If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. 5. Social Security Number 6. Sex . Age (In vrs. last birthday 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 M 2XX March 25,1936 Country) Director 212-36-8008 DC 75 Usual Residence of Decedent show 10a. State 10b. County with the Maryland 10c. City, Town or Location 10d. Inside City Limits must be notified at Director 28a-f 1 X Yes 2 No MD Prince George Laurel 10e. Street and Number 10f, Zip Code ō 10g. Citizen of What Country? Funeral items 23a 20707 USA 1012 Montrose Avenue filed within 72 hours after death 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14. Race - American Indian the Medical Examiner Armed Forces? If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. ō Š 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🖾 No Specify: If Yes, Give Year or Dates Specify: white "natural", 3 Widowed A Divorced Completed 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry U.S. Catholic (Specify only highest grade completed) (Give kind of work done during most of working Il Hygiene. life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Administrative Assistant Conference other traumatic event, Be permit. Page 1 and 2 should be filed. Department of Health and Mental Hy Important: If item 27 is marked oth any injury or other traumatic access. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Arthur Harding Laura Jacobs 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1012 Montrose Avenue, Laurel, Brandy McCray/ Daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State April 18 ☐ Burial 2XX Cremation 3 ☐ Removal from State West Arundel Crem. 2011 Odenton, MD 4 Donation 5 Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Donaldson Funeral Home, P.A. Ken 313 Talbott Ave., Laurel, MD 20707 M01053 23a. Fax 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line. Immediate Cause (Final Physician/ disease or condition resulting in death) Minutes Cardio-Pulmonary Arrest Medical Due to (or as a consequence of) **Examiner** Weeks Respiratory Failure Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that is it is to a second or injury that is it is to a second or injury that is it is a second or injury that is a second or injury that is a second or injury that is a second or injury that is a second or injury that is a second or injury that is a second or injury that is a second or injury that it is a second or injury that it is a second or injury that it is a second or injury that it is a second or injury that it is a second or injury that it Examiner Due to (or as a consequence of) Coronary Artery Disease Years and that initiated events resulting in death) Last Due to (or as a consequence of): attending physiciar Physician/Medical Hospital or Attending Physician: The law requires that the death certificate be IF FEMALE: yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery Live Birth 2 Fetal death 3 Ectopic pregna 5 Other (specify) Ectopic pregnancy in the past 12 months?
1 Yes 2 No Day Month Year Pregnant at time of death 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Multi Organ Failure 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4XXUnknown Were autopsy findings available prior to completion of cause of has autopsy performed? Yes 2 No death? 2XXNo Be 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: Other: 1 Yes 2 No ၉ 1 Inpatient 2 ER/Outpatient 3 IDOA 4 X Nursing Home 5 Residence 6 Other (Specify) this (27. Manner of Death 28a. Date of injury (Month, Day, Year) 28c. Injury at work? 1 ☐ Yes 2 ☐ No 28b. Time of Certificate: 28d. Describe how injury occurred 1XNatural injury 5 Pending Accident Suicide after death Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined 🖾 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check within 2 only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D19609 April 14, 2011 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Raman R. Tuli, 10810 Darnestown Road, Suite 202, Gaithersburg, MD 20878

DHMH 17 Rev 7/2009

State

Registrar

31. Date filed (Month, Day, Year)

1 9 2011

68760

Box

P.0.

Division of Vital Records,

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ EVERLY FERRELL 1139AM Medical Examiner y of Death senera Howa Olu mbia If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) Funeral 8. Date of Birth 1 □ M 2 🔀 F **Director** "natural", or items 23a or 28a-f show edical Examiner must be notified at 10a. State with the Maryland 10d. Inside City Limits Director olumbia 1 🗌 Yes 2 🐪 o 10e. Street and Numb 10g. Citizen of What Country? Funeral 21044 USA within 72 hours after death Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. þ 1 Never Married 2 Married 1 Yes 2 No Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: Completed 3 Divorced 4 Divorced Year or Dates the Medical 16a. Decedent's Usual Occupation (Give kind of work done during life. DO NOT var retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) permit. Page 1 and 2 should be filed within 73 Department of Health and Mental Hygiene. Important: If item 27 is marked other than any injury or other traumatic event, the Me College (1-4 or 5+) Be 17. Father's Name (First, Middle Grown 19b. Mailing Address (Street and Number of Husband 20a. Method of Disposition ☐ Burial 2 Cremation 3 ☐ Removal from State 25-2011 4 Donation 5 Other (Specify) au re of Funeral Service Licenses disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Interval Between Immediate Cause (Final Onset and Death Ph_sician/ OCARDIAL INFANCT ION disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Physician/Medical Examiner Due to (or as a consequence of): sate has been signed by the attending physician and page 2 should be detached for use as the burial-transit To the Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or iinjury that initiated events resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy 1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months?
1 Yes 2 No Pregnant at time of death
Unknown Month 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by Completed 1 Yes 2 No 3 Probably 4 Unknown 24a. Was an Were autopsy findings available After this certificate has autopsy prior to completion of cause of death? Yes 2 No 1 Yes 2 No 25. Was case referred to medical Certificate: To Be 26. Place of Death (Check only one) examiner? Hospital: 2 1 No 1 ☐ Inpatient 2 ☑ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify, 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending injury 1 ☐ Yes 2 ☐ No ☐ Accident ☐ Suicide Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29d. Date signed (Month, Day, Year) Soloh 10070109 2011 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Cedar Lane, Columbia M. State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene for State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ FOTOS 20/1 Creorge mon Medical 4a. Facility Name (if not institutio 4c. County of Death Examiner 4b. City, Town, or Location of Death deneral Itospital Olumbi howar 9. Birthplace (State or Fore 8. Date of Birth 7. Age (In vrs. last birthday) **Funeral** Months Min 1 🗶 M 2 🗆 F Yrs. **Director** 1920Massachusett 91 5400 Usual Residence of Decedent or 28a-f show 10a. State 10h County 10c. City, Town or Location 10d, Inside City Limits at Director event, the Medical Examiner must be notified Carroll Eldersburg MD 1 Yes 2 No 10f. Zip Code 10g. Citizen of What Country? by Funeral 23a 2405 Constantine Drive 21784 USA or items filed within 72 hours after death 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, 11. Marital Status Armed Forces?

1 A Yes 2 No
If Yes, Give Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify. Specify: "natural", White 3 X Widowed 4 Divorced ΙI Completed WW Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) than " John Hancock Life Elementary/Seconday (0-12) College (1-4 or 5+) Insurance Company <u>Administrator</u> marked other Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) permit. Page 1 and 2 should be filed Department of Health and Mental Hy Important: If item 27 is marked oth any injuy or other traumatic even once. ပ Eleftherious John Fotos Constantina 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Eldersburg, MD 21784 2405 Constantine Dr. Heather C. Houde, daughter 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place, 20c. Location - City or Town, State 1 🔀 Burial 2 🗆 Cremation 3 🗆 Removal from State Evergreen Cemetery 04/21/11 Boothbay, Maine Donation 5 Other (Specify) 21. Signature of Funeral Service Licensee George MacNabb 22. Name and Address of Facility MacNabb Funeral Home, P.A. Frederick Road Catonsville, MD 21228 301 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or spiratory arrest, shock, or heart failure. List only one cause on Onset and Death Immediate Cause (Final disease or condition Physician/ Medical resulting in death) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examiner Due to (or as a consequence of) Cause (Disease or iinjury and that initiated events resulting in death) Last Due to (or as a consequence of) attending physician Physician/Medical Hospital or Attending Physician: The law requires that the death certificate be Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?
1 ☐ Yes 2 ☐ No Month Year Day Pregnant at time of death Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Division of Vital Records, Certificate: To Be Completed 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy death? 2 🗌 No Yes 2 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospita 2 No ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) Inpatient 27. Mannar of Death Date of injury 28b. Time of 28c. Injury at 28d. Describe how injury occurred eral Director: After filled in by the funer (Month, Day, Year) injury work? 1 ☐ Yes 2 ☐ No Natural 5 Pending Investigation Accident 3 Suicide 4 Homicide Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) within 24 hours a Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) April 17, 2011 Rame and address of person who completed cause of death (Item 23a) (Type, Print)

Rame Sh Sabapa Mi 20)- 109 Back Rww New Road 201-

OHMH 17 Rev 7/2009

State Registrar

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Sabapalm

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death April 16^{Day} 2011 Wesley Griffin 12:15P M 4a. Facility Name (if not Institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Baltimore Gilchrist Hospice Towson Social Security Number If Under 1 Year 7. Age (In yrs. last birthday, If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign Days 1 X M 2 🗆 F Hours (Month, Day, Year) 03/20/1942 Nebraska 507-50-8550 69 Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 Yes 2 X No Baltimore Cockeysville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 6 Chris Eliot Court 21030 U.S.A. 12. Was Decedent Ever in U.S. Armed Forces? 1 ☑ Yes 2 ☐ No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11, Marital Status 14. Race - American Indian. Black, White, etc. 1 Never Married 2 X Married 1 ☐ Yes 2 K No Specify 3 Widowed 4 Divorced White Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life, DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) 5+ Physician Medical 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Griffin Kelly Arval Wesley Margaret Milton 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Diane E. Griffin / Wife 6 Chris Eliot Court, Cockeysville, MD 21030 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place 20c. Location - City or Town, State 1

Burial 2

Cremation 3

Removal from State 4 X Donation 5 ☐ Other (Spenify) 04/18/2011 Hanover, Maryland Anatomy Gifts Registry ral Service Lic+r see 22. Name and Address of Facility Anatomy Gifts Registry 7522 Connelley Dr., Ste. P, Hanover, MD 21076 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition hetasta resulting in death) Due to (or as a consequence of):

Physician, Medical Examiner

> -trans and

been signed by the a should be detached t

page 2 s

After this certificate

within 24 hours after death.

To the Funeral Director: After this certific completed filled in by the funeral director,

Hospital

Physician/

Medical

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Examiner

Funeral

Director

show

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"natural", or items 23a or edical Examiner must be

notified at

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Completed

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with the Maryland

within 72 hours after death

permit. Page 1 and 2 should be filed within 72 hour Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natu any injury or other traumatic event, the Medical

Baltimore, Maryland 21215-0036

Examine Completed by Physician/Medical Medical Certificate: To Be

or Attending Physician: The law requires that the death certificate be executed

Division of Vital Records, P.O. Box 68760

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events resulting in death) Last	Due to (or as a consection) Due to (or as a consection)				
IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown	3c. If yes, outcome of pregn 1 Live Birth 2 Fet 4 Pregnant at time of 9 Unknown	al death 3 🗌 Ect	opic pregnancy er (specify)		23d. Date of delivery Month Day Year
Part II. Other significant conditions cor	ntributing to death but not re	sulting in the underl	ying cause given in Part I.		2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?
25. Was case referred to medical			26. Place of Death (Ch		THOS ZEINO
examiner? 1 Yes 2 No	ospital: 1 ☐ Inpatient 2 ☐	ER/Outpatient 3	Other		e 6 Other (Specify) 1 Charles
27. Manner of Death 1 Natural 5 Pending 2 Accident Investigation	28a. Date of injury (Month, Day, Year)	28b. Time of injury	28c. Injury at work?	28d. Describe how in	
3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - At he building, etc. (Specify	ome, farm, street, fa	ctory, office	28f. Location (Street City or Town, St	and Number or Rural Route Number, ate)
(Check 2 \(\subseteq Medical Examina	er: On the basis of examinatio	n and/or investigation	ed at the time, date and place, n, in my opinion, death occurred occurred at the time, date and p	at the time, date and plant	ace, and due to the cause(s) and manner stated
29b. Signature and title of certifier			29c. License number	29d.	Date signed (Month. Dav. Year)

D71060

MD 21204

State

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

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			For State		S	State of M	larylar		artment of		Mental F	lygien	ne 201	E. region	12450
			Registrar	ne /Eiret Midd	0 (001)			Ce	rtificate of	Death	2. Date of	Reg. N	lo.		
	Physic		1000000000					Gilliam					2 20°		3 '56PM
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	Exami	ilei	Sinai Ho.			altimon	,			re City	atti		re, county of E	oatii	
	Funeral		5. Social Security N		6. Sex	7. A		last birthday)	If Under 1 Year Months Days	If Under 24 H	rs. 8. Date of	Birth Day, Yea	9.	Birthplace	(State or Foreign
	Director		213-88-5		1 ∐ M	2 💢 F	48	Yrs.	Months Days	1 lours Wi			62	Country	MD
	land ow		Usual Residence o	10b. County			10c. Ci	ty, Town or Lo	cation					10d.	Inside City Limits
	Marylan If show	ţ	MD	NA			В	altim	ore						Maria Yes 2 No
	hours after death with the Maryland tural", or items 23a or 28a-f show at Examinar must be neutited at	Funeral Director	10e. Street and Nu	mber					10f. Zip Code			10g. C	Citizen of What	Country?)
	23a c	<u>a</u>	2446 Wes	st Col	dspr	ing La	ane		21	215			U.S.	Α.	
	tems	nue	11. Marital Status		12.	Was Decedent Armed Forces' 1 □Yes 2	Ever in U	.S. 13.	Was Decedent of If Yes, specify Cub	Hispanic Origin? ban, Mexican, Pu	(Specify Yes or erto Rican, etc.)	No-	14. Race - A Black, W		ndian,
36	s afte	by F	1 Never Marr 3 □ Widowed		- 1	If Yes, Give	No		1 □Yes 2 🙀 No		, ,		Specify: I		k
21215-0036	2 should be filed within 72 hours after dea and Mental Hygiene. Is marked other than "natural", or items aumatic event, the Medical Examiner m	ed		15 Deceden	l's Educati	Year or Dates:		16a Dece	dent's Usual Occu	nation	-	16h	Kind of Busine		
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S	ould Mer narke	ဥ	Eddie L							_	n L. C		•		
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	permit. Pages 1 and 2 Department of Health Important: If item 27 i any Injury or other tra once.		20a. Method of Disp		augn	rer	20b. F		West C		ng Lan		Location - City		·
Baltimore,	permit. Pages 1 Department of I Important: If ite any Injury or ol once.		X☐ Burial 2 [4 ☐ Donation			oval from State	- 1		sition (Name of natory or other pla	i			ŕ		
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	/Medical Examiner		resulting in death)	3	€ a	Due to (or s	a consequ	uence of):	Negative Lenal ade	120.010					unys
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Box	eath certific attending p for use as t	jan/	23b. Was decedent in the past 12		1	If yes, outcome 1 ☐ Live birth	2 Feta	Ideath 3□	Ectopic pregnan	су			23d. Date of Month		Voor
Ö	at the de by the a tached i	ysic	1 ☐ Yes 2 ☐ 9 ☐ Unknown	ZNo		4 ☐ Pregnant a 9 ☐ Unknown	it time of d	leath 5∟	Other (specify) _	-			WORL	Day	Year
σ,	that the		Part II. Other signif	icant conditio	ns contrib	uting to death b	ut not resu	ulting in the un	iderlying cause giv	en in Part I.	23e. Did	I tobacco	use contribute	to the ca	ause of death?
Division of Vital Records,	w requires that s been signed b should be dett	d by	Type II	Diabete	e Mel	11725					1 [Yes 2	2 No 3□	Probably	4 Unknown
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Ä	The law cate has b page 2 st	mo									per	opsy formed?	prior	to comple ?	tion of cause of
'ita		Be C	25. Was case referr examiner?	ed to medical						26. Place of De	1 ∟ Yes eath <i>(Check onl</i>)	2 Z N one)	lo	es 2/2	INO
∑ \	Physician; rthis certificaral director, p		1 Yes 2 1		Hosp	1 Inpatie		ER/Outpatien	t 3 □ DOA Oth	er: 4 🗆 Nursing	Home 5 ☐ Re	sidence	6 □Other (S	pecify)	
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ĕ	after after Direction by	Certification: To	4 ☐ Homicide	determi	ned 2	building, et	c. (Specify	nie, iarni, stre	et, factory, office		City or To	(Street a own, Stat	and Number or te)	Rural Ro	ute Number,
	Hospital or Attend 24 hours after death Funeral Director: stely filled in by the	a	29a. Certifier	1 Certifyin	Physicia	an: To the best	of my know	wledge, death	occurred at the ti	me, date and pla	ce, and due to the	ie cause((s) and manner	as state	d.
	To the Hospital or Attending Physician: within 24 hours after deals. To the Funeral Director: After this certific completely filled in by the funeral director,	Medical	(Check only one)	2 Medical E	xaminer:	On the basis o	t examinat	tion and/or inv	estigation, in my	opinion, death oc	curred at the time	e, date ar	nd place, and o	lue to the	cause(s)
	To the within 2 To the I complet	Σ	29b. Signature and t	title of certifier	20		-		29c. Licens				ate signed (Mo		
				\sim	A	m	/			ES_00	0	Apr	11/6	201	1
D			30. Name and addre	R. C	ho comple	eted cause of d	eath (Item . Pトロ	23a) (Type, F	Print) THOCA Fal	of Balby	MOYE				
	Sta	te	Davi	p Day Year)	044	2. Registra	ar's Signa	ure	a corporat						
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last, 2. Date of Death 3. Time of Death : 21PM **Physician** 201 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Johns Hopkins Bayview Medical Center **Baltimore** 8. Date of Birth Month, Day, Birthplace (State or Foreign Country) If Under 1 Year If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** 1 □ M 2 🗷 F Months Days Hours Min 212-46-0470 Director Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show Examiner must be notified at 1 Yes 2 □ No Funeral Director 10f. Zip-Code 2/206 10e. Street and Number 10g. Citizen of What Country? ò Force USA "natural", or Items 23a 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 Never Married 2 Married Black 1 ☐ Yes 2 No Baltimore, Maryland 21215-0036 Specify. ð Specify: 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education Injury or other traumatic event, the Medical (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) Is marked other than Hospita lath stant 18. Mother's Name (First, Middle, Maiden Surname) 17, Father's Name (First, Middle, Last) Be and Mental 1-mma ဨ Tucker 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Brewster-granddaughter permit. Pages 1 and 2 s Department of Health ar Important; if Item 27 is any Injury or other trau atarsha Force 20b. Place of Disposition (Name of cemetery, crematory or other community of the community 20a. Method of Disposition 20c. Location - City or Town, State Date 1 Burial 2 Cremation 3 Removal from State 5 Other (Specify) 4 Donation 21. Signature /ansis IH 200 Fredhillon Poss Balto. MD 21229 23a. Part 1 Enter the disease, or complications that caused the death. Do not enter the mode of dying, shock or heart failure. List only one care is on each line. Approximate
Interval Between
Opset and Death
Out of Aurice
Office Aurice
Office Aurice
Office Approximate Immediale Cause (Final Physician disease or condition resulting in death) /Medical **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examiner Due to (or as a consequence of) or Attending Physician: The law requires that the death certificate be executed use as the bunial-trai attending physician and resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760点 Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 🗌 Ectopic pregnancy in the past 12 months? Month Day 5 Other (specify) 2 No the 9 Unknown 9 Unknown been signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? à 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 \(\text{Yes} \) 2 \(\text{Y} has 2 No 1 Yes Director: After this certificate 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Other: 4 Nursing Home Hospital 1 Yes 3 🗆 DOA 5 ☐ Residence 6 ☐ Other (Specify) Inpatient 2 FR/Outpatient ၉ filled in by the funeral Date of Injury (Month, Day Year) 28c. Injury at Work? 28d. Describe how injury occurred Manner of Death 28a. 28b. Time of Certification: 5 Pending investigation Natural Accident 1 Yes 2 No 3 Suicide Could not be Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined 4 Homicide City or Town, State) within 24 hours a

To the Funeral C the Hospital 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) one) and manner stated 29b. Signature and title of certifier 29c. License number 29d Date signed (Month, Day, Year) revamassielle RES-000 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) GENE ASSIELLO 4940 Eastern Avenue, Baltimore, MD, 21224 31. Date filed (Month, Day, Year) 32. Registrar's Signature State

DHMH 17 Rev 1/2001

Registrar

SINAL

State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month 2011 Physician/ 8:31 A M Barbara Lynne Gorschboth Apri] Medical 4c. County of Death 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** Baltimore Towson Gilchrist Center 9. Birthplace (State or Foreign If Under 1 Year If Under 24 Hrs. 8. Date of Birth 7. Age (In yrs. last birthday) Social Security Number **Funeral** Days Hours Feb 26, 1947 Maryland 1 □ M 2 🂢 F 220-80-6428 64 **Director** Usual Residence of Decedent 10d. Inside City Limits 28a-f show 10c. City, Town or Location 10b. County 10a. State **Funeral Director** permit. Page 1 and 2 should be filed within 72 hours after death with the Marylai Department of Health and Mental Hyglene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f si any injury or other traumatic event, the Medical Examiner must be notified a once. 1X Yes 2 ☐ No Baltimore N/A Maryland 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number USA 21206 4713 Greenhill Avenue Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Black, White, etc. þ 1 X Never Married 2 Married ☐ Yes 2 No Specify: White Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: If Yes, Give Completed 3 - Widowed 4 - Divorced Year or Dates 16b. Kind of Business Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4 or 5+) Elementary/Seconday (0-12) Disabled N/A 18. Mother's Name (First, Middle, Maiden Surname) Be 17. Father's Name (First, Middle, Last) Doris Evelyn Wallace မ Edward Marion Gorschboth 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 4713 Greenhill Avenue Baltimore, Maryland 21206 <u>Evelyn Cilipote, Sister</u> 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 X Cremation 3 Removal from State Baltimore, Maryland Metro Crematory Inc. 04/16/11 4 Donation 5 Other (Specify) Signature of Funeral Service Licensee Thomas Gregor Cremation Society Of Maryland, Inc. 299 Frederick Road Baltimore, Maryland 21228 homai 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ 215 1/0 disease or condition Medical s a consequence of resulting in death) Examiner Sequentially list conditions, if any, leading to humediate cause. Enter Underlying Cause (Disease or linjury Physician/Medical Examiner Hospital or Attending Physician; The law requires that the death certificate be executed that initiated events Due to (or as a consequence of): resulting in death) Last Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy 5 Other (specify) ____ in the past 12 menths? Pregnant at time of death g Unknown 9 Unknown P.O. I 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. To Be Completed by 1 Tes No 3 Probably 4 Unknown Division of Vital Records, 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 2 🗌 No 26. Place of Death (Check only one) 25. Was case referred to medical examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA 2 2 No 28a. Date of injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury at 27. Manner of Death Certificate: 1 Natural 2 Accide work? 5 Pending 2 🗌 No Accident Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) within 24 hours after de To the Funeral Directo completed filled in by the 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29c. License number 29b. Signature and title of certifier 15 2011 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 6701 N. Charles St 31. Date filed (Month, Day, Year) APR 1 9 201 State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene, Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 330 Medical 4a. Facility Name (if not institution, give street and number, 4b. City, Town, or Location of Death 4c. County of Death **Examiner** ANNE ARUNDEL UEENSTOWN SEVER 8. Date of Birth Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) Funeral Min Hours 1 XM 2 🗆 F 76 Director Usual Residence of Decedent 28a-f shov 10c. City, Town or Location Director 10a. State 10d, Inside City Limits within 72 hours after death with the Maryland other traumatic event, the Medical Examiner must be notified at 1 Yes 2 □ No 10g, Citizen of What Country? 9 10e Street and Numbe Funeral I items 23a Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14, Race - American Indian 11. Marital Status Armed Forces?
1 ☐ Yes 2 🗷 No ō þ 1 Never Married 2 Married 13 Maryland 21215-0036 1 ☐ Yes 2 💢 No Specify: If Yes Give "natural", Completed 3 Widowed 4 Divorced Year or Dates 15, Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry Il Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) permit. Page 1 and 2 should be filed wir Department of Health and Mental Hygie Important: If item 27 is marked other army injury or other traumatic event, th once. Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) ဂ္ 19a. Informant's Name/Relationship (Type, Print) (W) (E) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) ELWS TOWN Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) cemetery, crematory or other place HANOVER, MD Signature of Funeral Service Licensee 22. Name and Address of Facility 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition **Medical** resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events resulting in death) Last Physician/Medical Examiner Due to (or as a consequence of): ate has been signed by the attending physician and page 2 should be detached for use as the burial-transit Due to (or as a consequence of): To the Hospital or Attending Physician: The law requires that the death certificate be within 24 hours after death.

To the Funeral Director; After this certificate has been signed by the attending physicial completed filled in by the funeral director, page 2 should be detached for use as the bur Division of Vital Records, P.O. Box 68760 IF FEMALE: yes, outcome of pregnancy
☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Day Pregnant at time of death 5 Other (specify) Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by 2 No 1 Yes 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a Was an autopsy performed? Yes 2 No 25. Was case referred to medical 26. Place of Death (Check only one) Certificate: To Be examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b, Time of 28c. Injury at work? 1 ☐ Yes 2 ☐ No 28d. Describe how injury occurred 1 Natural 2 Accident 5 Pending Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical gertifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29c. License number 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 201 50470 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Gilen Burrie Highway #800° 310 32. Registras Signa State

DHMH 17 Rev 7/2009

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ ADPIC Medical 01 Pacility Name (if not institution, give street and number) County of Death **Examiner** 4b. City, Town, or Location of Death HARL ENIER If Under 24 Hrs. **Funeral** 7. Age (In yrs. last birthday) If Unde 8. Date of Birth 9. Birthplace (State or Foreign Country) MD Days Months Hours 1 1 M 2 M Month Day, 28-366 Director Usual Residence of Decedent 10b. County or 28a-f show 10a. State with the Maryland 10c. City, Town or Location 10d. Inside City Limits Funeral Director 1 Yes 2 No 10f. Zip Code Street and Number 10a. Citizen of What Country? "natural", or items 23a Page 1 and 2 should be filed within 72 hours after death Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Bace - American Indian Black, White, etc. 1 Dever Married 2 Married Completed by 1 Yes : Maryland 21215-0036 1 Yes 2 No Specify. 3 ₩ Widowed 4 □ Divorced Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b Kind of Business Industry (Specify only highest grade completed) marked other than Elementary/Seconday (0-12) College (1-4 or 5+) Be Eather's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ 19a. Informant's Name/Relationship (Type, Print) (Dawn nter) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 27 is r 1130X Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date Burial 2 Cremation 3 Removal from State cemetery, crematory or other place) 4 Donation 5 Other (Specify) Name and Address of Eacility 21. Signal Funeral Service License eral Hom 23a. Part 1. Enter the disease, or complications that caus, d the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each me. Approximate Interval Retween Immediate Cause (Final Onset and Death Physician/ disease or condition Medical resulting in death) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events resulting in death) Last Physician/Medical Examiner Due to (of as a consequen ate has been signed by the attending physician and page 2 should be detached for use as the burial-transit Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
9 ☐ Unknown 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State
Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Apronth 12, Mable M. Hicks 2011 12:29A.M. Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death Baltimore **Examiner** 4b. City, Town, or Location of Death Gilchrist Hospice Towson If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth

Months | Days | Hours | Min. | Apt Month | 2 y, Year 943 5. Social Security Number Funeral 7. Age (In vrs. last birthday) 9. Birthplace (State or Foreign 1 □ M 2 🖵 F 67 Washington, D.C. 215-28-1192 **Director** Yrs Usual Residence of Decedent 28a-f show 10a. State 10b. County 10c. City, Town or Location injury or other traumatic event, the Medical Examiner must be notified at 10d. Inside City Limits Director 1

√ Yes 2 □ No Maryland N/A Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? items 23a 21223 USA 2255 W. Baltimore Street 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status 14. Bace - American Indian Black, White, etc. 0 þ 1 Never Married 2 Married should be filed within 72 hours after and Mental Hygiene.
is marked other than "natural", or 1 Yes 2 DXNo Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify: Specify: Completed 3 Divorced 4 Divorced Black Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) 1th grade Sewing Machine Operator Acme Pad Corp Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Julia Ann Livsv James Lindv 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2255 W. Baltimore Street Baltimore, Maryand permit. Page 1 and 2 sh Department of Health ar Important: If item 27 is any injury or other trau Clarence Lindy/Brother 20b. Place of Disposition (Name of Kingere Memorating) of Pariet. 20a. Method of Disposition 20c. Location - City or Town, State Date 1 Removal from State 4/19/11 Woodlawn,Maryland 4 Donation 5 Other (Specify) 22. Name and Address of Facility Chatman-Harris Funeral 21. Signature of Funeral Service Licesee 5240 Reisterstown Road Baltimore,MD 21215 23a. Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Betweer Onset and Death Immediate Cause (Final Ph_sician/ > trolcc disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or impury that initiated events Examine Due to (or as a consequence of): Hospital or Attending Physician: The law requires that the death certificate be executed burial-tran Due to (or as a consequence of): resulting in death) Last Physician/Medical Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?

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DHMH 17 Rev 7/2009

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 18.APRIL 2011 LOIS JEAN HANSFORD 6:00 A Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death 8633 OAK RD BALTIMORE PARKVILLE 5. Social Security Number If Under 1 Year If Under 24 Hrs. 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 M 2 X Days Hours 216-32-0720 MAY 13, 1935 Country) Director 75 MD Usual Residence of Decedent show 10a. State 10b. County at 10c. City, Town or Location 10d. Inside City Limits Director 28a-f Examiner must be notified 1 ☐ Yes 2 🕱 No MD BALTIMORE PARKVILLE ŏ 10e. Street and Numbe 10f. Zip Code 10a. Citizen of What Country? items 23a Funeral 21234 USA 8633 OAK RD 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 No If Yes, Give 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black, White, etc. 0 þ 1 Never Married 2 Married 1 ☐ Yes 2 X No Specify: Specify: WHITE "natural" Completed 3 Widowed 4 X Divorced Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) within College (1-4 or 5+) the BUS DRIVER SCHOOL other Be filed Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Ith and Mental H 27 is marked or traumatic ever 2 Page 1 and 2 should be ment of Health and Ment ROBERT WILKINS MARGARET POPP 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, $941\ MOORES\ MILL\ RD\ BEL\ AIR,\ MD\ 21014$ DAVID HANSFORD-SON Important: If item 27 any injury or other tra 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State 1 K Burial 2 Cremation 3 Removal from State LORRAINE PARK CEM. 4/22/11 BALTIMORE, MD 4 Donation 5 Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility MILLER-DIPPEL FUNERAL HOME, BALTIMORE, MD 21206 6415 BELAIR RD Part 1. Enter the disease, shock, or heart failure. Lis implications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final EREBLOU Physician disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, Physician/Medical Examiner cause. 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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Certificate of Death Registrar 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ 18^{ay} APRIT. 2011 12:30 AM HERMAN **JOSEPH ALAN** Medical 4a, Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 8603 Briarcroft Lane Laurel Prince George's If Under 1 Year If Under 24 Hrs. 8. Date of Birth
(Month, Day, Year)
Aug. 2, 1952 9. Birthplace (State or Foreign Country) Massachusetts 5. Social Security Number 6, Sex 1 **X** M 2 □ F 7. Age (In vrs. last birthday) **Funeral** Days Hours Min. 58 Director 216-58-6288 Usual Residence of Decedent marked other than "natural", or items 23a or 28a-f show matic event, the Marical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2x No Prince George's Laurel 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? Funeral 8603 Briarcroft Lane 20708 USA 12. Was Decedent Ever in U.S. 13
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1 X Yes 2 No VIETNAMIf Yes, Give 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Never Married 2 X Married 2 Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🛛 No Specify: Specify: White 3 Divorced 4 Divorced Completed Year or Dates. 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business Industry Elementary/Seconday (0-12) College (1-4 or 5+) 12th WSSC 2 Supervisor other traumatic event, Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) should be file ည Stanlev Herman Antoinette Asci 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1 and 2 s of Health item 27 I Catherine B. Herman/Wife 8603 Briarcroft Lane, Laurel, MD 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State permit. Page 1 a
Department of H
Important: If ite
any injury or ot 1 Burial 2 X Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) West Arundel Crem. 4/20/2011 Odenton, MD 22. Name and Address of Facility Donaldson Funeral Home, Signature of Funeral Service Licenses M01103 313 Talbott Avenue, Laurel, MD 20707 23a, Part V. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, sho k, of heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final AMYOTROPHIC LATERAL SCLEROSIS Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Litter Underlying Cause (Disease or linjury Due to (or as a consequence of): sician and burial-transit that initiated events resulting in death) Last Due to (or as a consequence of) attending physician for use as the burial Physician/Medical death certificate be IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy
5 Other (specify) in the past 12 months?
1 Yes 2 No Month Day Year Pregnant at time of death the 9 Unknown 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? Yes 2 No page 2 certificate 25. Was case referred to medical 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 X Residence 6 Other (Specify) 1 Yes 2 No မြ 1 Inpatient 2 ER/Outpatient 3 DOA 24 hours after death. Funeral Director: After this 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: Hospital or Attending 1 X Natural 5 Pending 1 ☐ Yes 2 ☐ No Investigation filled in by the 3 ☐ Suicide 4 ☐ Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) Medical 🕭 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. within 2 To the 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) APRIL 18, 2011 MD# 33255 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) KAREN ANN BLACKSTONE, M.D., VAMC, 50 IRVING STREET NW, WASHINGTON, DC 20422/688 10 ed (Month, Day, Year) 32. Registrar's Signature State APR 1 9 2011

DHMH 17 Rev 7/2009

Registrar

P.O. Box 68760

Division of Vital Records,

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month FODURE 5:05a M 201 Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Baltimore 2412 Winchester Street Apt N Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth **Funeral** 9. Birthplace (State or Foreign 1 🛛 M 2 🗆 F Months Days Hours Min. (Month, Day, **05** Year) 214-64-8352 Director 55 Usual Residence of Decedent or than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director Baltimore Yes 2 No MD NA 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21216 2412 Winchester Street Apt N U.S.A. within 72 hours after death 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Armed Forces? Black, White, etc. <u>۾</u> 1 Never Married 2 Married 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates. Maryland 21215-0036 Specif Black 1 ☐ Yes 2 X No Specify. 3 Widowed 4X Divorced Completed 15. Decedent's Education 16a, Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) permit. Page 1 and 2 should be filed within 72 Department of Health and Mental Hygiene. Important: If item 27 is marked other than ' Blue Cross and Elementary/Seconday (0-12) College (1-4 or 5+) 12th grade Customer Service Blue Shield Be injury or other traumatic event, 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Cloyd Hughes Ardella L. Stuart 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 8211 Chandler Ct., Ellicott City, Md 21043 <u> Annette Thomas-Sister</u> Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 Burial 2X Cremation 3 Removal from State 4 Donation 5 Other (Specify) On-Site 4/18/2011 Baltimore, Md 21. Si mature of Funeral Service License 22. Name and Address of Facility March F/H West 4300 Wabash Ave, 21215 Baltimore, Md 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart fadure. List only one cause on such line. Approximate Interval Between Immediate Cause (Final disease or condition Onset and Death Physician/ Medical resulting in death) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying CANCER Exami Hospital or Attending Physician: The law requires that the death certificate be executed burial-transi Cause (Disease or iinjury that initiated events and Due to (or as a consequence of): resulting in death) Last physician Physician/Medical Division of Vital Records, P.O. Box 68760 the attending IF FEMALE: use 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ 1 Live Birth 4 Pregnant 9 Unknown o in the past 12 months?
1 ☐ Yes 2 ☐ No Day Year Pregnant at time of death cate has been signed by the page 2 should be detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a, Was an performe certificate | Yes 2 No 1 ☐ Yes 2 ☐ No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 2 No 1 🗌 Yes မ 1 Inpatient 2 ER/Outpatient 3 DOA After this 4 ☐ Nursing Home 5 Residence 6 ☐ Other (Specify, 27. Manner of Death 28a. Date of injury 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 X Natural (Month, Day, Year) 5 Pending injury after death. 1 🗌 Yes 2 🗌 No Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office 28f. Location (Street and Number or Rural Route Number, City or Town, State) completed filled in by 4 Homicide determined building, etc. (Specify) .124 hou.. •he Funeral Γ ·fille Medical Exertifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifier (Check within 2 To the P only one) Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Signa 29c. License number 29d. Date signed (Month, Day, Year) D0048160 4/14/2011 ss of person who completed cause of death (Item 23a) (Type, Print) Hausner,22 South Green Street, Baltimore, Md 21201

DHMH 17 Rev 7/2009

State

Registrar

31. Date filed (Month, Day, Year)

1 9 2011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

AMEND ITEM#11perFH, G914, 4/19/2011, WS
State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Day Month Year 2011 10:09a[™] <u>Janice Constance Hoffman</u> Apri Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death National Institutes of Health Bethesda Montgomery Social Security Number If Under 1 Year If Under 24 Hrs. 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 8. Date of Birth **Funeral** Days Min. 1 🗆 M 2 💢 F Hours 0570671938 Director 219-26-9482 72 MA Usual Residence of Decedent shov 10b. County 10a. State 10c. City, Town or Location 10d, Inside City Limits Director ral", or items 23a or 28a-f s Examiner must be notified 1 Yes 2X No MD BALTIMORE OWINGS MILLS 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 3420 ASSOCIATED WAY, #314 21117 USA death Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian. Black, White, etc. Completed by 1 Never Married 2 Married 1 Yes 72 hours after Maryland 21215-0036 1 Yes 2X No Specify: Specify 3 Widowed 4 X Divorced Year or Dates WHITE th and Mental Hygiene.
27 is marked other than "natur traumatic event, the Medical. 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15 Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) EDUCATION -Elementary/Seconday (0-12) College (1-4 or 5+) BALTIMORE CITY 5+ TEACHER Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ၉ permit. Page 1 and 2 should be Department of Health and Men Important: If item 27 is marke any injury or other traumatic. any injury or other traumatic. once. **JERRY** LEVITT ROSE BUTLER 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) HOWARD HOFFMAN/SON 1108 REGAL OAK DRIVE, ROCKVILLE, MD Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date ARL'INGTON CHIZUR AMUNO CEMETERY 1 X Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) 04/17/2011 BALTIMORE, MD 21. Signature of Funeral Service Licer 22. Name and Address of Facility SOL LEVINSON & BROS., INC. 8900 REISTERSTOWN ROAD, PIKESVILLE, MD 21208 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final et and Death Physician/ ertorated disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner niuos Sequentially list conditions Examiner any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to for as a consequence of: for use as the burial-transi that initiated events resulting in death) Last Due to (or as a consequence of) attending physician Physician/Medical Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?
1 ☐ Yes 2 🔀 No Month Year Day the 9 Unknown 9 Unknown P.O. ģ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Records, 1 ☐ Yes 2 🔀 No 3 ☐ Probably 4 ☐ Unknown Completed page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has autopsy performed? 2 No Yes 2 No 1 🗌 Yes Division of Vital completed filled in by the funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital Other: 2 No ၉ 1 Npatient 2 ER/Outpatient 3 I 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 24 hours after death.
Funeral Director. After this Certificate: 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Hospital or Attending 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No ☐ Accident ☐ Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner; On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. within 2 only one 29b. Signature and title of certifier 29d. Date; signed (Month, Day, Year) 2 MD PWD 10/2011 64823 3 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Michael Eberlein 10 Center Dr. Bethesda ,MD 20892 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar 19 2011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene = State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Physician/ Horowitz 12:00 PMM Florence 2011 APTI Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner BALTIMORE 7606 MEADOW WAY DUNDALK Social Security Number If Under 1 Year If Under 24 Hrs 8. Date of Birth g. Birthplace (State or Foreign 7. Age (In yrs, last birthday) Birtrip Country) NY **Funeral** 1 □ M 2 🕅 F Months Days Hours 0371371918 93 Yrs Director 050-16-7832 Usual Residence of Decedent show 10d. Inside City Limits 10b. County filed within 72 hours after death with the Maryland 10c. City, Town or Location Director "natural", or items 23a or 28a-f s edical Examiner must be notified 1 Yes 2 X No BALTIMORE DUNDALK 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21222 USA 7606 MEADOW WAY 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married þ Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify: 3 X Widowed 4 Divorced Completed WHITE Year or Dates ntal Hygiene. ed other than "natura event, the Medical E Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) EDUCATION TEACHER and Mental Hygie is marked other Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) 2 EPSTEIN ZALKIND SARAH permit, Page 1 and 2 should be Department of Health and Men Important: If item 27 is marke any injury or other traumatic once. LEEPO 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 10204 GREEN FOREST DRIVE, SILVER SPRING, MD 20903 SUSAN LEVINE / DAUGHTER Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place, Date 20c. Location - City or Town, State 1 X Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) OHEB SHALOM MEM. PARK:04/18/2011 REISTERSTOWN, MD Signature of Funeral Service Licensee 22. Name and Address of Facility SOL LEVINSON & BROS., INC. 8900 REISTERSTOWN ROAD, PIKESVILLE, MD 21208 23a. Part Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ Cardiovascular Disease Atheroschootic disease or condition Medical resulting in death) Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate Examine Due to (or as a consequence of) cause. Enter Underlying Cause (Disease or linjury the attending physician and hed for use as the burial-transit that initiated events Due to (or as a consequence of) resulting in death) Last Physician/Medical To the Hospital or Attending Physician: The law requires that the death certificate be P,O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy
5 Other (specify) in the past 12 months? Year Month Day Pregnant at time of death signed by the a d be detached for Yes Unknown g Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? b Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown plnous Completed 24b. Were autopsy findings available prior to completion of cause of 24a. Was an has performe Yes 2 🔽 1 ☐ Yes 2 ☐ No Division of Vital 25. Was case referred to medical 26. Place of Death (Check only one) director, Be examiner? Hospital 2 🗹 No Other: 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☑ Residence 6 ☐ Other (Specify, 잍 within 24 hours after death.

To the Funeral Director: After thi
completed filled in by the funeral 27, Manner of Death 28a. Date of injury 28b, Time of Certificate: 28c. Injury at 28d. Describe how injury occurred (Month, Day, Year) 1 Natural
2 Accident 5 Pending work? 1 ☐ Yes 2 ☐ No M Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 \square Homicide determined Medical 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Włajupilne M. D 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D0057465 4/17/11

Registrar

State

10

5-203

MD. 21209

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) N.S. Ray a Pa K.H., MID., 2835 Sm1th AV

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene ? State Registra Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Physician/ Charles Brutton Haverland April 2011 11:05 A M Medical 4a. Facility Name (if not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death **Examiner** Fairfield Nursing Center Crownsville Anne Arundel Co. If Under 1 Year If Under 24 Hrs. Social Security Number . Age (In yrs. last birthday 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Min 1 X M 2 🗆 Hours (Month, Day, Year) 1/16/1929 239-36-1542 Director 81 Usual Residence of Decedent or 28a-f show notified at 10b. County 10a. State 10c. City, Town or Location 10d. Inside City Limits with the Maryland Director MD 1 Yes 2 X No Anne Arundel Co. Glen Burnie 10e. Street and Number 10f. Zip Code ò 10g. Citizen of What Country? must be 23a Funeral 207 Norman Avenue 21060 United States items 2 death \ 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-11. Marital Status 14. Race - American Indian Examiner Armed Forces?

1 V yes 2 No WWII

If Yes, Give If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. 1 Never Married 2 X Married ō þ within 72 hours after Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify. Specify: "natural", 3 Divorced Completed White Year or Dates. -Vietnam the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) I Hygiene. College (1-4 or 5+) Elementary/Seconday (0-12) Social Security Disability Examiner Administration Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) th and Mental F 27 is marked of traumatic ever ပ William G. Haverland Ε. permit. Page 1 and 2 should be Department of Health and Ment Important: If item 27 is marke any injury or other traumatic once. Mae Greene 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mrs. Gisela M. Haverland/ Wife 207 Norman Avenue Glen Burnie, MD 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State 1X Burial 2 Cremation 3 Removal from State cemetery, crematory or other place, 4 Donation 5 Other (Specify) MD Veterans Cemetery 04/20/2011 Crownsville, MD 22. Name and Address of Facility Signature of Funeral Service Licen Singleton Funeral & Cremation Services PA; 2nd Ave SW: Glen Burnie, 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition Medical resulting in death) Examiner Sequentially list conditions, Examine it any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a nonsequence of and I-transit Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): attending physician a for use as the burial-Physician/Medical Division of Vital Records, P.O. Box 68760 IF FFMALE: use 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year Pregnant at time of death 5 Other (specify) 2 No g 🗌 Unknown the a 🗌 Hinknown s been signed by to should be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 🔀 No 3 ☐ Probably 4 ☐ Unknown Were autopsy findings available prior to completion of cause of 24a. Was an has autopsy page death? 1 ☐ Yes 2 X No 1 ☐ Yes 2 No certificate 25. Was case referred to medical 26. Place of Death (Check only one) funeral director, Be examiner? Hospital 2 No Other 1 🗌 Yes မှ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) this 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred 1 X Natural iniury work? 5 Pending within 24 hours after death.

To the Funeral Director: A completed filled in by the fu M 2 No Accident Investigation 3 ☐ Suicide 4 ☐ Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number determined City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifie (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one 29b. Signatur 29c. License number 29d. Date signed (Month, Day, Year) D38958 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Burnie MD21061 Frain Highway Sw Clean 10+1 208 State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month 2011 A M High Maribeth March 7:55 Medical 4a. Facility Name (if not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death **Examiner** Kensington Park Assisted Living Kensington Montgomery Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 □ M 2 🕅 F Days Months Hours Min. September 2.1936 370-36-2172 Country) Illinois **Director** 74 Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2X No Kensington Maryland Montgomery 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 3616 Littledale Road #314 20895 United States Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian Armed Forces?
1 ☐ Yes 2 🗓 No Black, White, etc. 1 \square Never Married 2 \square Married þ Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify: If Yes, Give Specify: 3 X Widowed 4 ☐ Divorced Completed Year or Dates White 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Own Home Homemaker Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ၉ Gardner M. Riley Barbara Heberling 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 10304 Folk Street, Silver Spring, Maryland 20902 William R. Landfair / Son 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place, 1 X Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) Arlington National Cemetery May 11, 2011 Arlington, Virginia 21. Signature of Funeral Service Licensee Robert Adres of Funeral Home/Rockville, 300 West Montgomery Avenue, Rockville, Maryland 20850-2805 M01360 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line Immediate Cause (Final Onset and Death Physician/ disease or condition resulting in death) Glioblastoma Medical Due to (or as a consequence of) Examiner Seizure Disorder Sequentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of): Examin or Attending Physician: The law requires that the death certificate be executed physician and s the burial-trans Hypertension that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 nding p IF FEMALE: use a 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery ☐ Ectopic pregnancy
☐ Other (specify) ___ in the past 12 months?
1 ☐ Yes 2 🔀 No
9 ☐ Unknown ĮQ. Month Day Year Pregnant at time of death ed by the a 9 Unknown signed b Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Completed I 1 🗌 Yes cate has been sig page 2 should b 2X No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a, Was an autopsy 2 No 1 Yes director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 2 X No Hospital: Other: 4 \(\text{Nursing Home} \) 5 \(\text{Residence} \) 6 \(\text{N Other (Specify)} \) 1 \(\text{Nursing Home} \) 1 ၉ 1 Inpatient 2 ER/Outpatient 3 DOA within 24 hours after death.

To the Funeral Director: After thi
completed filled in by the funeral o 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred X Natural work? 5 Pending 2 No Accident
Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specity) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined within 24 hours a the Hospital Medical X Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Me that Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Gentrying Number Practice on To the best of my knowledge death occurred at the time date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) March 24, 2011 D53691

Registrar

DHMH 17 Rev 7/2009

State

3200 Tower Oaks Boulevard #110, Rockville, Maryland 20852

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

Ajay Reddy, M.D.

31. Date filed (Month, Day, Year)

APR 1 9 201

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 0539 Heckstall Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death of Margiand Medical Center Inlugasith Baltimore N/ASocial Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Days Hours 1 XM 2 □ F Months o37671 1946 Maryland 218-44-8190 Director 65 Usual Residence of Decedent er than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits within 72 hours after death with the Maryland Director 1 Kyes 2 No N/A MD Baltimore 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? Funeral 607 George St. Apt 2 21201 U.S.A. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian, Armed Forces? Black, White, etc. þ 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 No Specify: If Yes Give Specify: 3 Widowed 4 Divorced Black Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life, DO NOT use retired) entary/Seconday (0-12) College (1-4 or 5+) 12th Grade Janitorial Univ. Hospital Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Department of Health and Mental Important, If item 27 is marked of any injury or other traumatic eve David Lee Heckstall Sr. Annie Williams t. Page 1 and 2 should by treent of Health and Mertant; If item 27 is mark 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 21229 Twilah Heckstall(daughter) 113 N. Rock Glen Rd. Apt K, Baltimore, MD timore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Burial 2 Cremation 3 Removal from State Mt. Zion Cem. 04/20/11 4 Donation 5 Other (Specify) Baltimore, MD Signature of Funeral Service Licensee Joseph dr. of Brown Jr. Funeral Home PA 2140 N. Fulton Ave., Baltimore MD 21217 art 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, of yieart failure. List only one cause on each line. Approximate Interval Between Onset and Death shock, of leart failu Immediate Cause (Final Bradycerdin Physician/ disease or condition resulting in death) 10 mins Medical Due to (or as a consequence of) Examiner Sequentially list conditions Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Hospital or Attending Physician: The law requires that the death certificate be executed 24 hours after death. ate has been signed by the attending physician and page 2 should be detached for use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
9 ☐ Unknown 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No 5 Other (specify) Month Day Year Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Completed 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? this certificate has autopsy 2 2 N Yes To the Funeral Director; After this certific completed filled in by the funeral director, Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? 2 No ျ 1 Inpatient 2 4 Nursing Home 5 Residence 6 Other (Specify, ER/Outpatient 3 DOA 27. Manner of Death Certificate: 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural injury work 5 Pending 2 Accident
3 Suicide
4 Homicide 1 Yes 2 No Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f, Location (Street and Number or Rural Route Number, determined City or Town, State Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated

State Registrar Jose

NasK

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Registrar's Signatu

Name and address of person who completed cause of death (Item 23a) (Type, Print)

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			For State	State of Maryland	Department of Health an	d Mental Hygie	ne	1 (1
			Registrar 1. Decedent's Name (First, Middle, La	st)	Certificate of Death	Reg.	No. 3. Time of	404
	Physicia Medi		Melburn	le_	Jacobs	Month .	Day Voor	35 AM
-	Examir	ner	4a Facility Name (if not institution, give 5. Social Security Number 6. S	ex. 17 Age (In vis Jast	4b. City, Town, or Location of Di		4c. County of Death Battimore O Rightplace (State	ov Foreign
	Funeral Director	ı	220 36-1585	M 2 D F		lin. April 3	9. Birthplace (State Country)	or Foreign
	yland f show ed at	ş	Usual Residence of Decedent 10a. State 10b. County	10c. City, To	wn or Location		10d. Inside C	
	the Mar or 28a- e notifie	Dire	10e. Street and Number	L B	10f. Zip Code	10a.	1 ☑ Ye	s 2 🗆 No
	th with ms 23a must b	Funeral Director	5009 Frankt	and Avenue	2120	6	USA	
980	within 72 hours after death with the Maryland giene. er than "natural", or items 23a or 28a-f sho ; the Medical Examiner must be notified at	by	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent Ever in U.S. Armed Forces 1 Yes 2 No If Yes, Give Year or Dates.	13. Was Decedent of Hispanic Origin? If Yes, specify Cuban, Mexican, Pu 1 □ Yes 2 ☑ No Specify:	(Specify Yes or No- lerto Rican, etc.)	14. Race - American Indian, Black, White, etc.	
21215-0036	ge 1 and 2 should be filed within 72 hours af tr of Health and Mental Hygiene. I fi item 27 is marked other than "natural", or other traumatic event, the Medical Exa	Completed	15. Decedent's E (Specify only highest gr Elementary/Seconday (0-12)		Sa. Decedent's Usual Occupation (Give kind of work done during most of life. DO NOT use retired)	working 16k	o. Kind of Business Industry	ept of.
d 21	be filed within sntal Hygiene. ked other that c event, the A	Be	17. Father's Name (First, Middle, Last)	0	Vlaintenance N 18. Mother's	Rame (First, Middle, Maid	ecree-tion + Pe	erks
Maryland	ould be file ad Mental marked of matic eve	욘	Clarence	Jacobs	Etho	2.1	Wells	
	1 and 2 shoul of Health and t item 27 is ma other traums		19a. Informant's Name/Relationship (7)	Jackson	9b. Mailing Address (Street and Number or	Rural Route Number, City	or Town, State, Zip Code) 41 Edge Word, M	040
ore,	ge 1 and it of Hea if item or other		20a. Method of Disposition 1 Burial 2 Cremation 3	20b, Place	of Disposition (Name of tery, crematory or other place)		Location - City or Town, State	ν
Baltimore,	t. Pag tmer rtant		4 ☐ Donation 5 ☐ Other (Special Service License)	Mary Mary	and National Park 4	20/2011 L	aurel, MD	
Ä	permi Depar Impor any ir		* Ldyssey.	Gray	2222 W. North	Ave Balt	1 Home, P.A.)
	Physician/	5 1	shock, or heart failure. List only o Immediate Cause (Final disease or condition	plications that caused the death. Do ne cluse on each line.	o not enter the mode of dying, such as card	liac or respiratory arrest,	Approxima Interval Be Onset and	tween
	Medical Examiner		resulting in death)	Duyto (or as a consequence	DANFILMONIA			
	od sit	Examiner	Sequentially list conditions, if any, leading to himselfut cause. Enter Underlying Cause (Disease or liniury	b. Due to (or as a consequence	e of):			
NB	executed ian and urial-transit		that initiated events resulting in death) Last	C. Due to (or as a consequence	e) of):			
09/	ate be physicia the bur	edica		d				
P.O. Box 68760	Hospital or Attending Physician: The law requires that the death certificate be 24 hours affer death certificate be 24 hours affer death affer this certificate has been signed by the attending physici tred filled in by the funeral director, page 2 should be detached for use as the but the death of the funeral director.		IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown	23c. If yes, outcome of pregnancy 1 Live Birth 2 Fetal dea 4 Pregnant at time of death 9 Unknown			23d. Date of delivery Month Day	Year
P.0	res that the signed by do be detact		Part II. Other significant conditions of	ontributing to death but not resulting	g in the underlying cause given in Part I.		to use contribute to the cause of	
ords,	v require been si should b	eted	Concastile H	eart tailur	2	-	2 No 3 Probably 4 24b, Were autopsy findings	
Records,	The law cate has page 2 s	Completed by	Dementia	wa wall	<u> </u>	24a. Was an autopsy performed 1 \square Yes 2	prior to completion of	
ita	Physician: The this certificate ral director, pag	Be	25. Was case referred to medical examiner?	Hospital:	26. Place of Death (C		12 10 2 2 10	
of V	g Phys er this eral dir	te: To	27. Manner of Death	1 Nnpatient 2 ☐ ER/0	Time of 28c. Injury at	g Home 5 Residence		
ion	ttending F death. tor: After i	Certificate:	1 Natural 5 ☐ Pending 2 ☐ Accident Investigation 3 ☐ Suicide 6 ☐ Could not b		injury work? M 1 Yes 2 No			
Division of Vital	To the Hospital or Attenu within 24 hours after deat To the Funeral Director. completed filled in by the		4 Homicide determined	28e. Place of Injury - At home, building, etc. (Specify)		City or Town, Sta		ber,
	the Hosp hin 24 ho the Fune mpleted fi	Medical	(Check 2 ☐ Medical Exami	ner: On the basis of examination and	, death occured at the time, date and place or investigation, in my opinion, death occurre wledge, death occurred at the time, date and	ed at the time, date and pla	ace, and due to the cause(s) and ma	anner stated.
	To t with To tl		29b. Signature and title of certifier	Som	29c. License number	29d.	Date signed (Month, Day, Year) 4 - 13 - 11	
	3		30 Name and address of person who o	U.D. TION (SICY Drive Tou	uson lan c		
	Stat	-	31. Date filed (Month, Day, Year)	32. Registra 's Signature	ed	III-O		-

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend #3 Per Phy C915 5/05/2011 JH #10d,11,12,&Barrent Maryland Department of Health and Mental Hygiene #10d,11,12,&Barrent Maryland Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ April 6;45a 281°1 Marjorie Johnson Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death **Examiner** N/A Harborside Nursing & Rehabilitation Center Baltimore If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign 8. Date of Birth 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** 1 🗆 M 2 🔏 Janth, Do Year 925 Country Maryland Hours Min. 214-54-7313 86 **Director** Usual Residence of Decedent 28a-f show 10d. Inside City Limits permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-1 show any injury or other traumatic event, the Medical Examiner must be notified at any injury or other traumatic event, the Medical Examiner must be 10b. County 10c. City, Town or Location 10a. State Director 1 Yes 2 □ No N/A Baltimore MD 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? by Funeral USA 21201 124 W. Franklin Street Apt. 1006 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No
If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify: Black 3 Widowed 4 Divorced Completed Year or Dates 15. Decedent's Education 16a, Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Seconday (0-12)

8th Grade College (1-4 or 5+) N/A Unemployed Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Maude Davenport William H. Johnson 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 414 Water Street Baltimore, Maryland 21201 Antwain Woodland — Great Nephew 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ■ Burial 2 □ Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify) 4/16/2011 Mt. Zion Cemetery Lansdowne, Maryland 22. Name and Address of Facility Chatman-Harris Funeral Home 21. Signature of Funeral Service Licen 5240 Reisterstown Road Baltimore, Maryland 21215 Ta 23a. Part 1. Enter the disease, or complications that caused shock, or heart failure. List only one cause on each line or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death Immediate Cause (Final Pnysician/ There sclee andio Vascular rears disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions, Examine Due to (brise a number querine of) cause. Enter Underlying
Cause (Disease or linjury Hospital or Attending Physician: The law requires that the death certificate be executed use as the burial-transit and that initiated events Due to (or as a consequence of) resulting in death) Last nding physician Physician/Medical Division of Wital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No
9 Unknown Month for Day Pregnant at time of death 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 2 No 3 Probably 4 Unknown 1 🗌 Yes Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 ☐ Yes 2 ☐ No 2 X N 25. Was case referred to medical examiner?
1 ☐ Yes 2 💢 No 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 X No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA မ 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: 1 Natural 5 \square Pending work's 1 Yes 2 No ☐ Accident ☐ Suicide Investigation 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 within 24 hours after de To the Funeral Directo completed filled in by the Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide Medical Kertifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 2 Medical Examiner: On the basis of examination and/or investigation, it into opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier D32158 15 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Rond Ste 108 Parikl , Cartonsville Jyothh 31. Date filed (Month, Day, Year) 32. Registrar's Signature State 1 9 2011 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ April 9:54P Jarzynski 2011 Rose Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Carrol1 292 Stoner Ave. Dove House westminster If Under 1 Year If Under 24 Hrs. Social Security Number 8. Date of Birth 9. Birthplace (State or Foreign Age (In yrs. last birthday) **Funeral** 1 M 2 T Days Hours Auguts tay, Year 1926 Mary land 216-20-3295 84 Yrs **Director** Usual Residence of Decedent 28a-f shov 10b. County 10a. State death with the Maryland 10c. City, Town or Location 10d. Inside City Limits Director notified 1 Yes 2 No Carroll Westminster Md. ö 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? must be Funeral 21157 USA 544 Oak Tree Road 11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. ö Completed by 1 Never Married 2 Married 1 ☐ Yes 2 💢 No If Yes, Give Year or Dates. permit. Page 1 and 2 should be filed within 72 hours after Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🔀 No Specify White Specify 3 Widowed 4 □ Divorced "natural" 15. Decedent's Education 16a, Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) than alth and Mental Hygiene. 27 is marked other than r traumatic event, the M Elementary/Seconday (0-12) College (1-4 or 5+) Store Clerk Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ John Schoenberger Rose Zimmerer 19a. Informant's Name/Relationship (Type, Print) 9b. Mailing Address (Street and Number of Bural Route Number, City or Town, State, Zip Code) 621 Kilmarnock Trail BelAir. Md. 21014 of Health a DTR. BelAir, Md. 21014 Maryrose Leach other t t: If item 20a. Method of Disposition
1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date Department o Important: If any injury or once. 4 ☐ Donation 5 ☐ Other (Specify) -2011 B 4-19-Gardens of Faith 21. Signature of Funeral Service Licensee 22. Name and Address of Facility 9705 Belair Road Nottingham, Md. 21236 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) Medical **Examiner** Sequentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of): Exami burial-transi and that initiated events Due to (or as a consequence of) resulting in death) Last attending physician for use as the burial Be Completed by Physician/Medical Division of Vital Records, P.O. Box 68760

ate has been signed by the atter page 2 should be detached for u certificate has To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifica completed filled in by the funeral director, I

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Certificate:

Medical

only one) 29b. Signature

31. Date filed (Month, Day,

APR 1 9 2011

Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar's Signature

	d					
IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 10 9 Unknown	23d. Date of de Month	livery Day Year				
Part II. Other significant conditions con		the cause of death?				
				24a. Was an autopsy performed?	prior to death?	topsy findings available completion of cause of
25. Was case referred to medical examiner? 1 Yes 2 No	lospital: 1	ER/Outpatient 3 🗆	26. Place of Death (Che	eck only one) Home 5 Residence	6 N Other (Spec	sifu No VP
27. Manne Death 1 Natural 5 Pending 2 Accident Investigation	28a. Date of injury (Month, Day, Year)	28b. Time of injury	28c. Injury at work? 1 ☐ Yes 2 ☐ No	28d. Describe how inju		House
3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of Injury - At he building, etc. (Specify		28f. Location (Street a City or Town, Stat	(Street and Number or Rural Route Number, wn, State)		
	cian: To the best of my know er: On the basis of examination					

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

DHMH 17 Rev 7/2009

State

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Amend Item 29 State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Pay 8:26 Physician/ ATON! Doris Johnson 2011 Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death Examiner 4b. City, Town, or Location of Death Doctor's Community Hospital Prince George's Lanham Social Security Number If Under 1 Year If Under 24 Hrs 8. Date of Birth 9. Birthplace (State or Foreign Funeral 1 M 2 🔯 Months Hours Sept I2, 1918 Massachusetts 039-07-2610 **Director** Usual Residence of Decedent show or 28a-f show notified at 10d. Inside City Limits 10a. State 10c. City, Town or Location with the Maryland Director 1 ☐ Yes 2x ☐ No Prince George's Berwyn Heights MD 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? ō or than "natural", or items 23a or the Medical Examiner must be re-Funeral USA 20740 6212 Seminole Place within 72 hours after death 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11 Marital Status 12. Was Decedent Ever in U.S. Armed Forces Black, White, etc. þ 1 X Never Married 2 ☐ Married 1 Yes 2 XNo Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: white Specify: Completed 3 Divorced 4 Divorced Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15 Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) and Mental Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) housewife own home Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 l and 2 should be fi f Health and Menta Leo Louis Robert Harriet Coupe 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a, Informant's Name/Relationship (Type, Print) permit. Page 1 and 2 sh Department of Health ar Important; If item 27 is any injury or other trau 6212 Seminole Place College Park, MD Robert Johnson/son 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State 4 X Donation 5 ☐ Other (Specify) Sign ur Erneral Single Brattend Attatomy "Board 655 W. Baltimore Street Director Baltimore, MD 21201 23a. Part 1 Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, on heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Pnysician/ advanced dementia Medical Due to (or as a consequence of) Examiner COPD Sequentially list conditions Examine if any, leading to immediate Due to (or as a consequence of) sician and burial-transit Cause (Disease or linjury that initiated events resulting in death) Last Due to (or as a consequence of): physician the burial Physician/Medical Hospital or Attending Physician: The law requires that the death certificate be Box 68760 attending p IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?
1 ☐ Yes 2 ☐ No Day Month Year Pregnant at time of death 4 ☐ Pregnant : 9 ☐ Unknown the 9 Unknown signed by the P.O. 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <u>م</u> 1 Yes Records, 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an cate has autopsy performe 1 Yes 2 No Yes 2 No this certificate **Division of Vital** 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be 2 1 No 1 Yes 1 Inpatient 2 🗆 ျှ ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) funeral 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: After 5 Pending injury 1 Natural 1 🗌 Yes Accident Investigation within 24 hours after death To the Funeral Director: / completed filled in by the 6 Could not be Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. To the within 2 To the F only one)

DHMH 17 Rev 7/2009

State

Registrar

29b. Signature and title of certifier

31. Date filed (Month, Day, Year)

APR

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30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Cecil George MD 7500 Hanover Pkwy Greenbelt, MD 20770

29c. License number

MDD 58182

29d. Date signed (Month, Day, Year) April 10, 2011

11-026/1		Please Type or Print in Black Indelible			jible.
Angelique Johns		State of Maryland / Department of 1- For State		ygiene	2011 12468
		Registrar Certificate C	of Death		g. No.
Physici Medical Exami		1. Decedent's Name (First, Middle, Last) Angelique Johnson		2. Date of Death Month April 7, 20	Day Year 1017 hrs
		4a. Facility Name (if not institution, give street and number) °	4b. City, Town, or Location of Death		4c. County of Death
		2230 W. Fayette Street	Baltimore		I MA
Funeral Director		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday)	If Under 1 Year If Under 24Hrs. Months Days Hours Min.	٦.,	h (MM/DD/YYYY) 9. Birthplace (State or Foreign
		2 1 4 - 6 4 - 6 3 1 9	s.	4-15-	2011 Country) MD
any		10a. State 10b. County 10c. City, Town or Local	ation		10d. Inside City Limits
▶	ŗ	MD N/A Baltin	iore		1 XYes 2 No
death with the Maryland or items 23s or 28s-f show must be notified at once.	Director	10e. Street and Number	10f. Zip Code	10	g. Citizen of What Country?
h the ? 3a or					
th wid	Funeral	1 Mayor Married 2 Married Armed Forces?	as Decedent of Hispanic Origin? (Sp Yes, specify Cuban, Mexican, Puerto		14. Race - American Indian, Black, White, etc.
er dea		3 Widowed 4 Divorced If Yes 2 No	Yes 2 No specify:	, , , , , , , ,	Specify: Black
ırs aft fural"	d	or Dates:	nt's Usual Occupation (Give kind of w	vork done	16b. Kind of Business/Industry
72 hou	etec	Elementary/Secondary (0-12) College (1-4 or 5+)	most of working life. DO NOT use retir		_
1036 vithin ene.	Completed	9th N/A Dis	sabled		Disabled
Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23s or 28s-f sho injury or other traumatic event, the Medical Examiner must be notified at once.		17. Father's Name (First, Middle, Last)	18.Mother's Name		aiden Surname)
212 ald be Menta marke	To Be	James Johnson 19a. Informant's Name/Relationship (Type, Print) 19b. Mailir	Debra g Address (Street and Number or R		er City or Town State Zin Code
AD 2 shot h and 27 is imatic	-	Debora Burrell-Mother 1529	7 Chateau A	w. Ba	1to, MD 21212
G, Pand I and Healt Fitem	1	20a. Method of Disposition 20b. Place of Dispo	sition (Name of cemetery,	Date	20c. Location - City or Town, State
Pages lent of r othe		1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other Specify:		16-2011	Lansdown MD
alti emit. epartm sports jury o	ı	21. Signature of Full eral Service Licensee 22.	Name and Address of Faility	arch F	H 1101 E. North
	113	13run- Markari A	Ve. Balto, MD 21	202	
Physician // // // // // // // // // // // // //		23a. Part I. Enter the disease, or complications that caused the death. Do not enter failure. List only one cause on each line. Multiple drug in	he mode of dying, such as cardiac or COXICATION INVOLV	respiratory arres	st, shock, or heart Approximate Interval Between Onset and
xaminer		Immediate Cause (Final disease or condition resulting in death) a (Morphine), methadone, Due to (or as a consequence of):	citalopram and Be	nzodiaz	epines Death
		Sequentially list conditions b.			
	Examiner	if any, leading to immediate Due to (or as a consequence of): cause. Enter Underlying Cause			
	Хаш	(Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of):			
an ecu	ical E	d.			
F	ള	■ MENDED 23a,27,28a-f,p	er me,g915 5-19-	11 sm	
876 ificate ig phy s the b		IF FEMALE: 23c. If yes, outcome of pregnancy 3b. Was decedent pregnant in the	etal death 3 Ectopic pregnar		23d. Date of delivery Month Day Year
x 60	ပ၊	past 12 months?	ther (Specify)	ioy	Mondi Bay roa
he dea	Physi	1 Yes 2 V No 9 Unknown 9 Unknown			
3, P.O. Bc ires that the dea ir signed by the a	ă ă	Part II. Other significant conditions contributing to death but not resulting in the	underlying cause given in Part I.		acco use contribute to the cause of death? 2 No 3 Probably 4 Unknown
ords, w require is been sig should be	Completed			24a. Was ar	
Cords law requi	힏			autops: perform	y prior to completion of cause of
tal Recian: The certificate		25. Was case referred to medical	26.Place of Death (Check o	1 ✓ Yes 2	No 1 ✓ Yes 2 No
Vital Rec hysician: The l this certificate l	8	examiner? Hospital: 4 Innetion 2 FR/Outpetion	IOthor -		tesidence 6 🗸 Other: Scene
of \ ding Phy.	Ηħ	1 Yes 2 No I impatient 2 Erocutpatient 22 Recompation 27. Manner of Death (Month, Day, Year) 28b. Time of (Month, Day, Year)			ow injury occurred
ion tendin eath. tor: A	탏	Natural 5 Pending Fd 4-7-11 fd 6:50) pm 1 Yes 2 x No	Unknown	
Divisi pital or Att ours after de neral Direct filled in by	Certification:	3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, stre	et, factory, office building, etc.	28f. Location (St	reet and Number or Rural Route Number, City
Ospital hours aneral		4 Homicide determined (Specify) Found at Resid			re,Md.
Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physici completely filled in by the funeral director, page 2 should be detached for use as the buri	ल	29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occur one) 2 Medical Examiner: On the basis of examination and/or investiga			
To vit	Š	29b, Signature an Juttle of certifier and manner stated.	29c. License number		29d. Date signed (Month, Day, Year)
	-	Cuth valle veet	O.C.M.E.	Į.	April 8, 2011

State 31. Date filed (Month, Day, Year)
Registrar APR 1 9 2011 DHMH 17 Rev 1/2001 OCME 2006

ORIGINAL

30. Name and address of person who completed cause of death (Item 23a)

OCME

Assistant Medical Examiner

32. Registrar's Signature

Victor Weedn MD JD

111 Penn Street, Baltimore, MD 21201

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 3. Time of Death 2. Date of Death 1. Decement's Name (First, Middle, Last) Day Physician bnes 0049 04 /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Speci Bal trume Homital If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. 8. Date of Birth (Month) Play, 9. Birthplace (State or Foreign Social Security Number 85 42 369 **Funeral** arolina 12 M 2□F Months 185 42 3697 Usual Residence of Decedent Director permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Importent: If item 27 is marked other then "natural", or items 23a or 28e-f show 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location orient: If item 27 is marked other then "natural", or items 23a or 28e-f shov injury or other traumatic event, the Mudical Exara at must be inxiffed at Baltimore 1 Yes 2 No Director IND 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 21213 1622 Funeral 14. Race - American Indian. . Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify: Specify: Back ģ 3 Widowed 4 Divorced Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation (Give kind of work done during most of working life, DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) JUNES College (1-4or 5+) hanic 171 18, Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be e unk. 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Balto, MD Crenchaw Ln. rionce 20b. Place of Disposition (Name of 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State CREMATORY * 4 □ Donation 5 □ Other (Specify) 21229 21. Signature Juneral Service Licensee 22. Name and Addr s of Facility 23a. Parv. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Pnysician Man Ischemic Careliam yopethy /Medical Due to (or as a consequence of) Dugestive Heart Failure, Atrial Fibrilation Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner burial-transit Lyertemin Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, betructive Sleep Agnes Physician/Medical as the b IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 1 ☐ Live birth 3 Ectopic pregnancy for Month Day Year in the past 12 months? 1 ☐ Yes 2 ☐ No 4☐Pregnant at time of death 5 Other (specify) page 2 should be detached 9☐ Unknown 9 🗆 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 3 ☐ Probably 4 ☐ Unknown 1 ☐ Yes 2 ☐ No Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 No 24a. Was an 1 Yes 2 \ No To the Hospital or Attending Physician: completely filled in by the funeral director, 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: 4 Nursing Home 1 Inpatient 2 ER/Outpatient 3 DOA 5 ☐ Residence 6 ☐ Other (Specify) P 1 Yes 2 No 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death 28b. Time of Director: After Injury 5 Pending 1 Natural 1 ☐ Yes 2 ☐ No death. investigation 2 Accident 6 Could not be 3 🗀 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 Homicide within 24 hours a To the Funerel C Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 0006935 Temesgen 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) South charles St, Baltimine, MD 21230 MD respensi 32. Registrar's Signature 31. Date filed (Month, Day, Year) State

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State Registrar

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1. Date filed (Month, Day, Year)

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible, State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month ones 5.05PM osephine Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death Maris tospice IUWSor altimore Social Security Number 6. Sex In yrs. last birthday) If Under If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign Country) **Funeral** . Age 1 🗆 M 2 🗓 83 Yrs. Months Days Min. **Director** Usual Residence of Decedent 28a-f show 10b. County 10a. State 10c. City, Town or Location death with the Maryland aţ 10d. Inside City Limits Director Examiner must be notified 1 Nes 2 No ō 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral items 23a 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. 6 þ 1 Never Married 2 Married 1 Yes If Yes, Give 2 No 1 ☐ Yes 2 No Specify: Specify "natural" Completed 3 Widowed 4 Divorced Year or Dates the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b, Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) 27 is marked other than Elementary/Seconday (0-12) College (1-4 or 5+) Be Maryland 17, Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Health and Mental ည permit. Page 1 and 2 should be 1 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and No umber or Rural Route Number, <u>City</u> or Town, State, Zip Code) (A) Ma Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date Important: If it any injury or o once. Department of Burial 2 ☐ Cremation 3 ☐ Removal from State 4 Donation 5 Other (Specify) of Funeral Service Licensee 22. Name and Address of Facility 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line. Immediate Cause (Final Playaician/ disease or condition resulting in death) Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of): Cause (Disease or iinjury use as the burial-trans that initiated events resulting in death) Last Due to (or as a consequence of): attending physician Physician/Medical IF FEMALE: 23b. Was decedent pregnant 23d. Date of delivery Live Birth 2 Fetal death 3 Ectopic pregnancy
5 Other (specify) ____ in the past 12 months?
1 Yes 2 No Month Day Year Pregnant at time of death by the Unknown or Attending Physician: The law requires that Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Certificate: To Be Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autop-performe this certificate 2 🗆 No 1 🗌 Yes **Division of Vital Director:** After this certific d in by the funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Natural 5 Pending 1 Yes Accident Investigation 6 Could not be Suicide 4 Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) completed filled in by 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined within 24 hours a the Hospital Medical 29a, Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title 29d. Date signed (Month, Day, Year) pleted cause of death (Item 23a) (Type, Print) 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Day **Physician** 4. 45PM JAMES KUNDELIS APRIL 2011 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner NIA Community living Center Lock KNUEN HIMOR If Under 1 Year | If Under 24 Hrs 9. Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) Sept. 19,1928 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** Min. Months 214-26-0846 1 M 2 ☐ F 82 Director Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at 10d. Inside City Limits 10c. City, Town or Location 10a. State Baltimore Y Yes 2 □ No MD Director 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code USA 21230 2035 Griffis Avenue Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1∰ Yes 2 □ No If Yes, Give Year or Dates: 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 XNo Specify: Specify:White Be Completed by 3 ₩ Widowed 4 Divorced 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Auditor Banking 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Demetrius Kondelis Thelma Whitten 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Brenda Sensibaugh/daughter 2035 Griffis Avenue Balto. MD 21230 Date 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 1X Burial 2 □ Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify) Crownsville Cemetery 4/20/1 Crownsville MD 21. Signal re V Juneral S Nice Lic nsee 22. Name and Address of Facility 300 MAce Ave. Balto. MD Connelly Funeral Home of Essex 21221 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) relodysplashi Sundrime **Physician** /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner Physician: The law requires that the death certificate be executed burial-trar and Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760, physician Physician/Medical the as IF FEMALE: use 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐Ectopic pregnancy Month Day Year for in the past 12 months? 1 ☐ Yes 2 ☐ No 4☐Pregnant at time of death 5 ☐ Other (specify) 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ģ pe 3 Probably 4 Denknown 1 ☐ Yes 2 ☐ No Completed page 2 should 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy performed death? 1 □Yes 2 ☑ No 1☐ Yes 2 No funeral director, 25. Was case referred to medical examiner? 26. Place of Death Check onl one Be Hospital: Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3□ DOA Certification: To After this 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 27. Manner of Death 28d. Describe how injury occurred Hospital or Attending 5 ☐ Pending investigation Injury 1 Natural n 24 hours after death.

ne Funeral Director: Af bletely filled in by the fun 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 1 [Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical within 24 hou To the Fune completely fi 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 700 Luch RAVENBLUI BALTIMORE, MD 21218 MD SURES It Shim de 32. Registrar's Signature 31. Date filed (Month, Day, Year) State Registrar

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ April Day 2011 Nina Jean Kamerer 18 12:15 AM Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death STELLA MARIS HOSPICE Timonium Baltimore County Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth May 23, 1924 7. Age (In vrs. last birthday **Funeral** 9. Birthplace (State or Foreign Min. 1 - M 2 X F Days Hours 86 Indiana Director 216-20-3886 May Usual Residence of Deceden or 28a-f shov notified at show 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director Maryland|Baltimore County 1 🗌 Yes 2 💢 No Towson 10e. Street and Number ò 10f. Zip Code 10g. Citizen of What Country? or than "natural", or items 23a or the Medical Examiner must be Funeral 409 Virginia Avenue, 21286 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Bace - American Indian Black, White, etc. þ 1 Never Married 2 Married ☐ Yes 2 💢 No Yes, Give Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 X No Specify. Completed 3 Widowed 4 Divorced Specify: White 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) al Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) Executive Secretary Freight Company traumatic event, Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) and Mental H ၉ Department of Health and Ment Important: If item 27 is marken any injury or ... Karl Frederick Kamerer Naomi Dinkledine 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) ROYSTON, Mueller, McLean & Reid, LLP 102 W. Pennsylvanja Ave, #600, Towson, MD 21 William Blue, Esq. (Pers. Rep. 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 🕅 Burial 2 🗆 Cremation 3 🗆 Removal from State Lorraine Pk Mausoleum 4/20/2011 Baltimore, Maryland 4 ☐ Donation 5 ☐ Other (Specify) Signature of Functial Service Lie MITCHELL-WIEDEFELD FUNERAL HOME, IN 6500 York Road, Baltimore, Maryland Martin D. Lawson 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) **PNEUMONIA** Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, Examine cause. Enter Underlying Cause (Disease or linjury that initiated events Due to Cirias a gansacuerice of resulting in death) Last Due to (or as a consequence of) burialphysician Medical Division of Vital Records, P.O. Box 68760 the attending pl IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months?
1 Yes 2 No Month Year Pregnant at time of death Day been signed by the should be detached 9 Unknown Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Completed has been sign 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 X No page After this certificate 1 Yes 25. Was case referred to medica Be 26. Place of Death (Check only one) examiner? Hospital: Other: 2 X No ျပ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 NO Other (Specify) HOSPICE 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred Hospital or Attending injury work?
1 \(\sum \) Yes 2 \(\sum \) No **X** Natural 5 Pending Director: / Accident Investigation 6 Could not be Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined within 24 hours a Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 X Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one)

0 State Registrar 29b. Signature and tale

JACKIE JONES,

19

31. Date filed (Month, Day, Year,

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

CRNP

DHMH 17 Rev 7/2009

2011

NINA KAMERER

TIMONIUM, MD 21093

2300 DULANEY VALLEY RD.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene - State Registrar Certificate of Death Rea No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ April 11, Day 2011 Year 10:00 P M Kessler William Medical 4a. Facility Name (if not institution, give street and number, 4b. City, Town, or Location of Death **Examiner** 4c. County of Death Montgomery Silver Spring Holy Cross Hospital 6. Sex 1 M 2 D F Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign 8 Date of Birth **Funeral** Months Days Hours Director 71 212-38-1819 Germany February 1940 Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

any injury or other traumarked other than "natural" 10a. State 10b. County 10c. City. Town or Location 10d. Inside City Limits Director Bethesda 1 Yes 2 X No Maryland Montgomery 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral United States 20817 8704 Eggert Drive Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces?
1 ☒ Yes 2 ☐ No 1 Never Married 2 Married Black, White, etc. þ 1 ☐ Yes 2 X No Specify: If Yes Give Specify: White Completed 3 Widowed 4 Divorced Year or Dates. 1962-1968 15. Decedent's Education Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Wholesale Goods 0wner Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ഉ William Kessler Lillian Friedlander 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 8704 Eggert Drive Bethesda, Maryland 20817 Gisela Rosa Kessler / Wife 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State April Date 15. cemetery, crematory or other place)
Montgomery
Crematorium, Inc. 1 Burial 2 X Cremation 3 Removal from State 4 Donation 5 Other (Specify) 2011 Bethesda, Maryland 21. Signature of Funeral Service License Robert A. Pumphrey Funeral Home, Bethesda-ChevyChase, Inc. 7557 Wisconsin Avenue Bethesda, Maryland 20814 Klee MO1607 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Onset and Death **Physician** Hemorrhagic Conversion of ischemic stroke disease or condition Medical resulting in death) Due to (or as a consequence of) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examiner Due to (or as a consequence of) Cause (Disease or iinjury Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of) Completed by Physician/Medical Division of Vital Records, P.O. Box 68760 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death
4 Pregnant at time of death
9 Unknown 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day Year s been signed by the s should be detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Coronary Artery Disease (CAD) 1 ☐ Yes 2 ☐ No 3 🙀 Probably 4 ☐ Unknown has been 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an Hyperlipidemia page 2 autopsy performed' certificate ☐ Yes 2 🔀 No 1 ☐ Yes 2 🛛 No funeral director. Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital: Other: ၉ 1 Yes 2 X No 1 X Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) After this 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred injury 1 🔀 Natural 5 Pending 1 Yes 2 No after death Director: / Accident Investigation filled in by the 3 ☐ Suicide 4 ☐ Homicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 🕱 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Configuration Number Prantition T. The basis of my included by 3 act occurred at the time, date and place, and due to the cause(s) and manner at attack. (Check within 2

To the I 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 4/12/2011 D69288 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar

DHMH 17 Rev 7/2009

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32. Regia ar's S

1500 Forest Glen Road Silver Spring, Maryland 20910

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ APRIL Year Lillian Roxane Lynott 11:45 PM Medical Oil 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death HOSPITAL AGNES BALTIMORE N/A Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth Sep. 23, Year 1943 **Funeral** 9. Birthplace (State or Foreign 1 M 2 XF Director Maryland 212-40-0537 67 Usual Residence of Decedent ıral", or items 23a or 28a-f shov I Examiner must be notified at with the Maryland 10c. City, Town or Location Director 1 🗆 Yes 2 🛂 No Baltimore Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21227 United States 3168 Shiloh Court permit. Page 1 and 2 should be filed within 72 hours after death v Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items any injury or other traumatic event, the Medical Examiner mu Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian Black, White, etc. þ 1 Never Married 2 Married 1 Yes 2 No If Yes, Give 21215-0036 1 ☐ Yes 2 X No Specify: White Completed 3 ¥ Widowed 4 □ Divorced Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Education Teaching Assistant Be Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname, မ Davis Breeding Louise Virginia Mitchell 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 700 Spotters Ct. Hampstead Maryland 21074 Gerald T. Lynott, Jr. - Son Baltimore, 20a. Method of Disposition

| Comparison | Comparison | Comparison | Comparison | Comparison | Comparison | Comparison | Comparison | Comparison | Comparison | Comparison | Comparison | Comparison | Comparison | Comparison | Comparison | Comparison | Comparison | Comparison | Comparison | Comparison | Comparison | Comparison | Comparison | Comparison | Comparison | Comparison | Comparison | Comparison | Comparison | Comparison | Comparison | Comparison | Comparison | Comparison | Comparison | Comparison | Comparison | Comparison | Comparison | Comparison | Comparison | Comparison | Comparison | Comparison | Comparison | Comparison | Comparison | Comparison | Comparison | Comparison | Comparison | Comparison | Comparison | Comparison | Comparison | Comparison | Comparison | Comparison | Comparison | Comparison | Comparison | Comparison | Comparison | Comparison | Comparison | Comparison | Comparison | Comparison | Comparison | Comparison | Comparison | Comparison | Comparison | Comparison | Comparison | Comparison | Comparison | Comparison | Comparison | Comparison | Comparison | Comparison | Comparison | Comparison | Comparison | Comparison | Comparison | Comparison | Comparison | Comparison | Comparison | Comparison | Comparison | Comparison | Comparison | Comparison | Comparison | Comparison | Comparison | Comparison | Comparison | Comparison | Comparison | Comparison | Comparison | Comparison | Comparison | Comparison | Comparison | Comparison | Comparison | Comparison | Comparison | Comparison | Comparison | Comparison | Comparison | Comparison | Comparison | Comparison | Comparison | Comparison | Comparison | Comparison | Comparison | Comparison | Comparison | Comparison | Comparison | Comparison | Comparison | Comparison | Comparison | Comparison | Comparison | Comparison | Comparison | Comparison | Comparison | Comparison | Comparison | Comparison | Comparison | Comparison | Comparison | Comparison | Comparison | Comparison | Comparison | Comparison | Comparison | Comparison | Comparison | Comparison | C 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory, or other place)
Meadowridge
Memorial Park 5 Other (Specify) 4-18-2011 Elkridge, MD eure of moral Service I 22. Name and Address of Facility Ambrose Funeral Home, Inc. 1328 Sulphur SPring Rd., Arbutus, MD 21227 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Immediate Cause (Final Onset and Death Physician/ disease or condition resulting in death) CHRONIC OBSTRUCTIVE WNG monling Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of): To the Hospital or Attending Physician: The law requires that the death certificate be executed signed by the attending physician and I be detached for use as the burial-transi Cause (Disease or linjury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Records, P.O. Box 68760 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) in the past 12 months?
1 Yes 2 No Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ HEART FAILURE Completed 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed Yes 2 No 1 Yes Division of Vital 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner?
1 Yes 2 No Other: 욘 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending 1 Yes 2 No 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, within 24 hours a

To the Funeral I

completed filled Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the Lead of my knowledge, of all occurred at the time, date and place, and due to the cause(s) and manner stated. (Check 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) M.D P 23748 APXI, 13,2011 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) RAJANI JAGANA 900 SOUTH CATON AVENUE, BALTIMORE, MD 21229 31. Date filed (Month, Day, Year) 32. Pegistrar's Signature State Registrar

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ RICHARD M. LEBERKNIGHT APRIL 15. 201°1 6:05 P M Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death BALTIMORE GILCHRIST HOSPICE TOWSON Social Security Number Birthplace (State or Foreign Country) **Funeral** 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 1 🔀 M 2 🗆 F Days Hours APRIL 28, 1935 212-34-6755 75 **Director** MD Usual Residence of Decedent 28a-f shov 10a, State 10b. County 72 hours after death with the Maryland 10c. City, Town or Location Examiner must be notified at 10d. Inside City Limits Director 1 X Yes 2 No MD BALTIMORE N/A10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? items 23a Funeral 6429 WALTHER AVE UNIT A 21206 USA 11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. "natural", or Completed by 1 Never Married 2 Married 1 ☐ Yes If Yes, Give 2 XNo Maryland 21215-0036 1 ☐ Yes 2 X No Specify: WHITE 3 ₩ Widowed 4 Divorced Year or Dates traumatic event, the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) ould be filed within 72 nd Mental Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) ANITOR EDUCATION Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည ALICE E. MACBETH MAX LEBERKNIGHT 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 st Department of Health a Important: If item 27 is any injury or other tra HIGHLAND PARK, NJ 08904 504 S. 2ND AVE APT 1 RAYMOND LEBERKNIGHT-BROTHER Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State 1 Sp Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) cemetery, crematory or other place, PARKWOOD CEMETERY 4/20/11 BALTIMORE, MD 21. Signature of Funeral Service Licensee 22. Name and Address of Facility MILLER-DIPPEL FUNERAL HOME, INC BALTIMORE, MD 21206 6415 BELAIR RD 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ Metaltata disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of): Exam or Attending Physician: The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): physician a s the burial-1 Physician/Medical Division of Vital Records, P.O. Box 68760 attending pl IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?
1 ☐ Yes 2 ☐ No Day Pregnant at time of death Month Year 9 Unknown Unknown ò Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Completed 1 Yes 2 No 3 Probably 4 Onknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an cate has autopsy performed? certificate 1 Yes 2 W 1 Yes funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital: 2 🖳 🔨 ၉ 1 Inpatient 2 ER/Outpatient 3 DQA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death nours after death.

neral Director: After the filled in by the funeral Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 2 Accident 5 Pending 1 ☐ Yes 2 ☐ No Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined within 24 hours a

To the Funeral I

completed filled Medical 29a. Certifier Sertifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Gertifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month, Day, Year) D71040 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) KUMAR ND 212 CL

DHMH 17 Rev 7/2009

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Elijah Izael Lajeune		ate of Maryla	nd / Depart	ment of I	Health and		lygiene	201	1 12477
Physician/	Registrar Certificate of Death						2. Date of Dea	Reg. No. 2. Date of Death 3. Time	
Medical Examiner	Elijah Izael La Jeuness						April 13, 2	Month Day Year 0505 h April 13, 2011 4c. County of Death	
4	4a. Facility Name (if not institution Howard County Gene		mber)		. City, Town, or t Columbia	ocation of Deat	n	Howard	Deali
Funeral	5. Social Security Number		7. Age (In yrs. last		If Under 1 Year Months Days	If Under 24Hr		1	9. Birthplace (State or Foreign Country)
Director	212. 91- 4001 Usual Residence of Decedent	1 ⋈ м 2 F		3 Yrs.	World Duy		12 05	2007	Country)
80y	10a. State 10b. County		10c. City, To	own or Location					10d. Inside City Limits
Maryland 28a-f show d at once. ector	10e. Street and Number	ward			10f. Zip Code		-13	0g. Citizen of Wha	1 Yes 2 No
r death with the Maryland or items 23a or 28a-f sho must be notified at once. Funeral Director	9685 Basket	ring Rea	d #3			045		U.S	
th with cms 23 (the no)	11. Marital Status 1 ,Never Married 2 M	12. Was Dec	edent Ever in U.S.	13. Was	Decedent of Hisp , specify Cuban,	panic Origin? (S Mexican, Puerto	specify Yes or No o Rican, etc.)	14. Race - White,	American Indian, Black, etc.
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hours afte antural" <u>Examine</u> ed by	15. Decedent's Education (Spe			6a. Decedent's during mos	Usual Occupati t of working life.	on (Give kind of DO NOT use re	work done tired)	16b. Kind of Busi	
5-0036 ed within 72 hour fygiene, other than "matu the Medical Exam Completed	Elementary/Secondary (0-12)	4 or 5+)	or 5+)				Infant		
	17. Father's Name (First, Middle, Robert La.				1			Maiden Surname)	Hess Cole
2121 ould be fill d Mental H s marked fic event, i	19a Informant's Name/Relations	hip (Type, Print)		19b. Mailing A	Address (Street	and Number or	Rural Route Nu	nber. City or Town.	State, Zip Code)
MD and 2 shows alth and 27 in raumat	Juaquinia La 20a. Method of Disposition	Deuness			Basket on (Name of cen		Date #3		ity or Town, State
10re, 1988 l a at of He t: If ite	1 Burial 2 Cremation		om State cre	matory or othe			()		or Mill, MD
altir	4 Donation 5 Other Sp 21. Signature of Funeral Service	pecify: Licensee	IKITE	22. Na	me and Address	of Facility \ (Lughn Ca	GreeneF	cultral servicus
	23a. Part I. Exter the disease, or	complications that ca	aused the death. D	181	28 Liber	MU KOO	ur Kano	MISTOWN	MID 21133
Physician //Medical	failure. List only one cause Immediate Cause (Final disease	on each line.							Between Onset and Death
<i>E</i> xaminer	or condition resulting in death)	Due to (or as a	consequence of):						
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause									
(Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of):									
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'60, ate be e ohysicia ne buria	IF FEMALE:	23c. If yes, o	, 28a-f, pe outcome of pregnar	f,per me,g916 6-22-11 sm				23d. Date of delivery	
23d. Date of de Month FEMALE:						Day Year			
Boy he death the for att		9 Unkno				ivan in Part I	23e Didt	obacco use contrib	ute to the cause of death?
P.O. es that the igned by edetac	Yes 2 ✓ No 1 Yes 2 ✓ No 24a. Was an autopsy						_	No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of	
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Recont The law page 2							1 Yes		ath? ✓ Yes 2 No
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Division rate of a train after death. The and Diversors A Bredie death. The division of the first death. Bettiff cation	2 Accident Inves	stigation 28e Place		e, farm, street,	-	es 2 X No		assault Street and Number	
25. Was case referred to medical examiner? 26. Place of Death (Check only one) 27. Manner of Death 28. Date of Injury 28.							State) 9685 Ba .a , Md	treet and Number or Rural Route Number, City ate) 9685 Basket Ring Rd #2 a,Md.	
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To the H. within 24 To the Fr completel	29b. Signature and title of certifie	and manner st	tated.		29c. License	number		29d. Date signed	(Month, Day, Year)
	lelin	11			O.C.N	И.Е.		April 14, 201	1
00	30. Name and address of person Zabiullah Ali, M.D.	who completed caus Assistant Medic			Street, Balti	more, MD 2	1201		
State	31. Date filed (Month, Day, Year)	32. Fe	gistrar's Signature	-1-	4.1	*- \ '-			acist.
Registrar DHMH 17 Rev 1/2001	APR 1	2017 /	sur p	ORIGINAL					OCME

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene, 1 - State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ OK OON Medical 4a. Facility Name (if not institution, give street and number **Examiner** 4b. City, Town, or Location of Death 4c. County of Death ELLICOTTC HOWAR 00 5. Social Security Number 6. Sex Age (In yrs. last birthday)
Yrs. 8. Date f Birth **Funeral** If Under 24 Hrs 9. Birthplace (State or Foreign 219-88-44 1 M 2 F Director Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mantal Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examina. 10a, State 10b. County Director 10c. City, Town or Location 10d. Inside City Limits 1 Yes 2 □ No MI 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral . Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No If Yes, Give 11. Marital Status 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12 14. Race - American Indian Black, White, etc. þ 1 Never Married 2 Married 1 Yes 2 No Specify Completed 3 Widowed 4 Divorced Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ၉ HWANG 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, 20a. Method of Disposition 20b. Place of Disposition (Name of Date Burial 2 Cremation 3 Removal from State cemetery, crematory or other 4 ☐ sonation 5 ☐ Other (Specify) 21. Signatu 22. Name and A Houma. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner Sequentially list conditions Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of): been signed by the attending physician and should be detached for use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical the Hospital or Attending Physician: The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 IF FEMALE 23b. Was decedent pregnant 23d. Date of delivery Live Birth 2 Fetal death 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Pregnant at time of death 5 Other (specify) Month Day Vear 9 Unknown 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? Oronor 24 hours after death.

Funeral Director: After this certificate has page 2 autopsy performe Yes 2 No the funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospita 1 🗌 Yes Other ည 1 Inpatient 2 ER/Outpatient 3 IDOA Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred Natural 5 Pending 1 🗌 Yes Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) completed filled in by 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Certifying Physician: To the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner stated. within 2 To the only one) 29b. Signature and title of certifier 00053150 30. Name and address of person who Lute completed cause of death (Item 23a) (Type, Print) Ld 96 21045 50

State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last 2. Date of Death Gordon Henry Merritt, Jr. Physician/ Day 2011 April 14, 6:55 A.M Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Gilchrist Hospice Center Towson Baltimore Social Security Number If Under 1 Year If Under 24 Hrs. Age (In vrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Days 1 🛛 M 2 🗌 F March 13,1967 Maryland **Director** 212-96-9228 44 Usual Residence of Decedent 28a-f shov 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Examiner must be notified at Director 1 ☐ Yes 2 X No MD Baltimore Halethorpe 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? items 23a Funeral 21227 USA 3014 Georgia Avenue 11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. ō ð 1 Never Married 2 Married 1 ☐ Yes 2 🗓 No If Yes, Give Baltimore, Maryland 21215-0036 within 72 hours after Specify: White 1 ☐ Yes 2 X No Specify: "natural", Completed 3 Widowed 4 Divorced Year or Dates the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) permit. Page 1 and 2 should be filed within 72 Department of Health and Mental Hygiene. Important: If item 27 is marked other than any injury or other traumatic event, the Meagne. Elementary/Seconday (0-12) College (1-4 or 5+) Retail Mall Maintenance Be 17. Father's Name (First, Middle, Last, 18. Mother's Name (First, Middle, Maiden Surname) Gordon H. Merritt, Sr. Nancy Gortt 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Gordon H. Merritt, Sr Son 3014 Georgia Avenue; Halethorpe, MD 21227 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place)
Balto-Wash Crematory 1 \square Burial 2 \boxtimes Cremation 3 \square Removal from State 4/18/2011 Laurel, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Sterling Ashton Schwab Witzke Funeral Home of Catonsville, Inc. of Funeral Service Licensee 630 Edmondson Avenue: Catonsvill 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate shock, or heart failure. List only one cause on each line. Interval Between Immediate Cause (Final Onset and Death Physician/ Non 5 may CIN disease or condition VI CU Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions Examine Due to for as a gensecuence of cause. Enter Underlying Cause (Disease or iinjury that initiated events resulting in death) Last the Hospital or Attending Physician: The law requires that the death certificate be executed burial-transi and Due to (or as a consequence of): physician Physician/Medical Division of Vital Records, P.O. Box 68760 the attending p IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) ___ in the past 12 months? Pregnant at time of death be detached 9 Unknown Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy page certificate 1 ☐ Yes 2 No Yes funeral director, Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital Other: မ 1 Inpatient 2 ER/Outpatient 3 IDOA 4 Nursing Home 5 Residence After this 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: Time of 28c. Injury at 28d. Describe how injury occurred 1 Z Natural injury work? 1 ☐ Yes 2 ☐ No 5 Pending after death. Accident Investigation leted filled in by the 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined 24 hours Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 29a. Certifier (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one 29b. Sian 29c. License number nd address of person who completed cause of death (Item 23a) (Type, Print) N. Charles ST Tonson mg Hornis M

Registrar

Date filed (Month)

Day,

APR 19

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death . Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Stac Mack 6:05 PM .01 Medical 100 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death ylana timore If Under 1 Year If Under 24 Hrs. rity Number 7. Age in yrs. last birthday 8. Date of Birth (Month, Day, 9. Birthplace (State or Foreign Country) **Funeral** 212-90-6538 1 M 2 1 Min. Hours **Director** Usual Residence of Decedent shov Page 1 and 2 should be filed within 72 hours after death with the Maryland ortant: If item 27 is marked other than "natural", or items 23a or 28a-f sho injury or other traumatic event, the Medical Examiner must be notified at 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 No mor 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian. Black, White, etc. 1 Never Married 2 Married Be Completed by 1 Yes Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify: d Mental Hygiene. marked other than "natural", 3 🗆 Widowed 4 🗆 Divorced Blac Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working 16b. Kind of Business Industry (Specify only highest grade completed) Baltimore. life. DO NOT use retired) conday (0-12) College (1-4 or 5+) Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Mac permit. Page 1 and 2 shoul Department of Health and I Important: If item 27 is m 19a. Informant's Name/Relationship (Type, Print) Farther) 19b. Mailing Address (Street and Number or Rural Boute Number, City or Town, State, Zip Code) D +2 20a. Method of Disposition 20b. Place of Disposition (Name of 20c Location - City or Town, State Date 1 Burial 2 Cremation 3 Removal from State cemetery, crematory or other place 4 Donation 5 Other (Specify) 21. Signatu V of Funeral Service Licens any in once, Name and Address of Fac 35 eral 23a. Part 1 Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Physician ulmonary disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examiner Due to (or as a consequence of): Cause (Disease or iinjury that initiated events To the Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-tran Due to (or as a consequence of) resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?
1 ☐ Yes 2 ☑ No Day Year Pregnant at time of death 5 Other (specify) signed by the a 9 Unknown Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Obesity - profound 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown has been sign 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 No page After this certificate 1 Yes 2 No Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital Other: 2 No 잍 1 ☐ Inpatient 2 ☑ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death Certificate: 28a. Date of injury 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred (Month, Day, Year) 1 Matural injury 5 Pending Accident 1 Yes 2 No Investigation To the Funeral Director: completed filled in by the Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office 4 Homicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined building, etc. (Specify) within 24 hours a

To the Funeral I Medical 1 💆 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifiei Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 29b. Signature and title of certifier 29c. License number allin D0060081 13 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Maryland General Hospital 10 31. Date filed (Month, State

DHMH 17 Rev 7/2009

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend #1 Per Phy G 14 4 19/2011 III State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 3. Time of Death 2. Date of Death Month. Anna Mae Mainz Day Physician/ Year 7011 4:45 A Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Baltimore Seasons Hospice NW Hospital Randallstown If Under 1 Year | If Under 24 Hrs. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth **Funeral** Birthplace (State or Foreign 1 □ M 2 X F Days Hours Country Mary land 69 Septh. 23 Yel 941 Director 212-42-7639 Usual Residence of Decedent 28a-f shov 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 27 is marked other than "natural", or items 23a or 28a-f s traumatic event, the Medical Examiner must be notified Catonsville MD Baltimore 1 Yes 2X No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21228 900 S. Rolling Road USA 11. Marital Status 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-14. Race - American Indian, Armed Forces? If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. White 1 🖔 Never Married 2 🗆 Married þ ☐ Yes Baltimore, Maryland 21215-0036 within 72 hours after 1 Yes 2 No Specify: If Yes, Give Completed 3 Widowed 4 Divorced Year or Dates 16a. Decedent's Usual Occupation
(Give kind of work done during most of working Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) and Mental Hygiene. life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Disabled Disabled unknown Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ၉ William Henry Mainz Irene G. Bury 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 sh.
Department of Health ar
Important: If item 27 is
any injury or other trau Gerry Rickel-Guardian 705 Glen Allen Drive Baltimore Maryland 21229 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other place)
Atlantic Crematory 1 Burial 2 XCremation 3 Removal from State Apr. 19, 2011 Glen Burnie Maryland 4 Donation 5 Other (Specify) 22. Name and Address of Facility Ambrose Funeral Home Inc. eral Service Licensee ure of F any 1328 Sulphur Spring Road, Arbutus Maryland 21227 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final Physician/ Preumonia disease or condition Medical resulting in death) Due to (or as a consequence of): **Examiner** cardiovasiular disease Amenositeratio Sequentially list conditions, If any, loading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of) Exami attending physician and for use as the burial-transit To the Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months? Month Pregnant at time of death Day Year 2 No 9 Unknown 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of 24a. Was an certificate has page 2 performed? Yes 2 No death? 1 Yes 2 No Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital 4 Nursing Home 5 Residence 6 Tother (Specify) Other: 1 ☐ Yes 2 ☑ No ည 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA within 24 hours after death. To the Funeral Director: After this Manner of Death 28a. Date of injury Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred Natural (Month, Day, Year) 5 Pending work' 1 Yes 2 No Accident Investigation completed filled in by the Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier 🗹 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29b. Signature and title of certifier

MSL (4) WWW.M.D 29d. Date signed (Month, Day, Year) 00057465 4/15/11 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) N 5 Ray apaker / M P (6934 M) at on Glen Burnie, ND. 21061 6934 Aviation RIVO 31. Date filed (Month, Day, Year) strar's Signature State

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Dav Year Physician/ 10:28AM Elizabeth Julia Manke Apri 201 Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner 740 Falconer Road Joppa Harford If Under 24 Hrs. 5. Social Security Number 7. Age (In vrs. last birthday, 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 - M 2 - F Country) Months Days Hours Min. (Month, Day, Year 93 Director Dec. 09. 1917 Maryland 215-10-8365 Usual Residence of Decedent show 10d. Inside City Limits 10b. County 10c. City, Town or Location the Medical Examiner must be notified at Director 28a-f 1 Yes 2 X No Maryland Harford Joppa 10f. Zip Code 23a or 10e. Street and Numbe 10g. Citizen of What Country? by Funeral 740 Falconer Road 21085 United States within 72 hours after death 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? Race - American Indian, Black, White, etc. 11 Marital Status 6 1 Never Married 2 Married Yes 2 No Yes, Give Baltimore, Maryland 21215-0036 1 ☐ Yes 2√ No Specify: "natural", Specify: White 3 Widowed 4 Divorced Completed Year or Dates 15 Decedent's Education 16a Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) other than College (1-4 or 5+) Elementary/Seconday (0-12) Hygiene. Baltimore County Executive Secretary Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) and Mental His marked of 2 Page 1 and 2 should be Joseph Lieb Theresia Schneider 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 sh Department of Health ar Important: If item 27 is any injury or other trau 740 Falconer Road Joppa, Maryland 21085 Theresa Manke (Daughter) 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place April 20, XXBurial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) Holy Redeemer Cemetery 2011 Baltimore, Maryland Signature of Funeral Service License 22. Name and Address of Facility Evans Funeral Chapel & Cremation Services-Parkville 8800 Harford Road Parkville, Maryland 21234 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or fear, failure. List only one cause on each line.

Immediate Cause Final Interval Between Onset and Death Pnysician/ C063 disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner heart disease valvalor Sequentially list conditions, Examine if any, leading to immediate cause. Litter Underlying Cause (Disease or linjury Due to (or as a consequence of): attending physician and for use as the burial-transil that initiated events Due to (or as a consequence of): resulting in death) Last by Physician/Medical the Hospital or Attending Physician: The law requires that the death certificate be Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months?

1 Yes 2 XNo
9 Unknown Month Year Day Pregnant at time of death 9 Unknown P.O. ed by t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Tes 2 No 3 Probably 4 Unknown Division of Vital Records, Certificate: To Be Completed 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy performed? Yes 2 No death? 1 ☐ Yes 2 ☐ No 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital 2 W No 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) the Funeral Director; After thin ppleted filled in by the funeral 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural injury 5 Pending work? M Accident Investigation Suicide 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined within 24 hours a To the Funeral L Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check 29b. Signature and title of certifier 29c, License number 29d. Date signed (Month, Day, Year) D44271 who completed cause of death (Item 23a) (Type, Print) M.D 01 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene-Certificate of Death Reg. No 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Year Medical Facility Name (if not institution, give street and number **Examiner** 4b. City. Town, or Location of Death 4c. County of Death 1esAPeA 6. Sex Date o. (Month, Day, If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign **Funeral** Age (In yrs. last birthday, 8. Date of Birth 1 ★ M 2 □ F Months Days Min. Day, Year Hours Director 219-62-0903 1955 West Apr Usual Residence of Deceden 10a State 10b. County 10c. City, Town or Location Director r 28a-f s notified White Hall Maryland | Harford County 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? must be Funeral 5313 Long Corner Road 21161 USA 11. Marital Status 12. Was Decedent Ever in U.S Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Examiner 14. Race - American Indian, ō þ 1 Never Married 2 X Married Black, White, etc. 1 ☐ Yes 2 🏋 No If Yes, Give 1 ☐ Yes 2 X No Specify: "natural" Completed 3 Widowed 4 Divorced Year or Dates the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Traffic Manager Meat Processing Plant Be Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) and Mental F is marked or 2 Robert Theodore McCartin other traumatic Elma Betty Lee Ritenour 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) of Health of Item 27 i Cheryl L. McCartin <u>5313 Long Corner Road, White Hall, Maryland 21161</u> Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State X Burial 2 Cremation 3 Removal from State Department or Important: If any injury or 4 ☐ Donation 5 ☐ Other (Specify) Jessops Cemetery 4/21/2011 Cockeysville, Maryland Sign re of perals libe to se martin D. Lawson 22. Name and Address of Facility MITCHELL-WIEDEFELD FUNERAL HOME, INC. 6500 York Road, Baltimore, Maryland 21212 J. 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart fallure. List only one cause on each line. Immediate Cause (Final Physician/ disease or condition resulting in death) Medical a consequence of Examiner Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury Due to (or as a consequence of): that initiated events resulting in death) Last Due to (or as a consequence of) attending physician Physician/Medical 145008 IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death

4 Pregnant at time of death

9 Unknown 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months? Month 2 No by the a 9 Unknown that the Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Records, 1 Yes 2 No 3 Probably 4 Unknown 24a. Was an autopsy 24b. Were autopsy findings available prior to completion of cause of death? performe certificate I Yes 2 1 Tes Vital To the Hospital or Attending Physician: Be 25. Was case referred to medical 26. Place of Death (Check only one) 2 No Other: ၉ 1 Yes 1 Inpatient 2 ER/Outpatient 3 IDOA 4 Nursing Home 5 Residence 6 Other (Specify) of 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending injury Division work? Investigation Accident 2 🗆 No Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) ☐ Homicide determined within 24 hours a To the Funeral C Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one 29b leath (Item 23a) (Type, Print) 30. Name and address of person who completed cause of Regist State

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Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygienes for State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 000 5,2011 1526 Medical ot institution, give street and number) **Examiner** 4b. City, Town, or Location of D 4c. County of Deat a115 spits Chal If Under If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) **Funeral** Age (In vrs. last birthday) 1 Year 9. Birthplace (State or Foreign 1 X M 2 □ F Months Hours Min. Country) Director 218-09-7328 90 VA Usual Residence of Decedent 28a-f show ms 23a or 28a-f shor must be notified at 10a. State 10b. County with the Maryland Director 10c. City. Town or Location 10d. Inside City Limits Baltimore MD NA 1 X Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21217 U.S.A. 2914 Auchentoroly Terrace items 2 filed within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No If Yes, Give 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. ō þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🕅 No Specify. 3√ Widowed 4 Divorced Specify: "natural" Completed Black Year or Dates Medical 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) ar than " the № ith and Mental Hygiene.
27 is marked other than r traumatic event, the Mo ementary/Seconday (0-12) College (1-4 or 5+) Pimlico Race Track Cashier 8th grade Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) permit. Page 1 and 2 should be filk Department of Health and Mental Important: If item 27 is marked of any injury or other traumatic eve once. Ollie Mae Walker ည George Murray 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) $\,\,21117$ 9100 Thistledown Road Apt 382, Owings Mills Michael Murray-Son 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Burial 2 Cremation 3 Removal from State Garrison Forest Vet 4/22/2011 Owings Mills, Md Donation 5 D Other (Specify) of Funeral Service License 21. Si datu 22. Name and Address of Facility
March F/H West
4300 Wabash Ave, 21215 Baltimore, 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or hear failure. List only one cause on each line. Interval Between Se Immediate Cause (Final Onset and Death Physician. PS1. disease or condition resulting in death) Medical Due to (or a consequence of): Examiner Sequentially list conditions. if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of): Examir Hospital or Attending Physician: The law requires that the death certificate be executed 24 hours after death.

Funeral Director: After this certificate has been signed by the attending physician and and tran that initiated events resulting in death) Last Due to (or as a consequence of) attending physician a for use as the burial-Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?

1 Yes 2 No 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ Pregnant at time of death Month Day Year sate has been signed by the page 2 should be detached 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? δ Completed 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 Yes funeral director, 25. Was case referred to medica Be 26. Place of Death (Check only one) examiner? Hospital 2 No 1 🗌 Yes Other: မ 1 npatient 2 ER/Outpatient 3 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 27. Manner of Death Date of injury 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred (Month, Day, 1 Natural 5 Pending 1 🗌 Yes Accident Investigation completed filled in by the 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. To the within 2 3 🗆 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifler 29c. License number Date signed (Month, Day, Year) 30. Name and address person who completed cause of death (Item 23a) (Type, Print) euch 19277 LAV 31. Date filed (Month, Day, Year) State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

AMEND ITEM#26perpHYS, G914, 4/19/2011, WS
State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Day 2011 April 17, Marlene Hicks McCormick 3:30 A M Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death 114 Judges Lane Towson Baltimore 1 Year If Under 24 Hrs. 8. Date of Birth
Days Hours Min. (Month, Day,
July 6, Social Security Number 7. Age (In vrs. last birthday) **Funeral** 9. Birthplace (State or Foreign 1 X M 2 □ F Months 6, 1931 Maryland 79 **Director** Yrs 218-28-5523 Usual Residence of Decedent or 28a-f show notified at 10a. State 10b. County within 72 hours after death with the Maryland 10c. City, Town or Location Director 10d. Inside City Limits MD Baltimore 1 ☐ Yes 2 🛣 No Towson 10e. Street and Number ō 10f. Zip Code 10g. Citizen of What Country? "natural", or items 23a or Funeral 114 Judges Lane 21204 USA 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian. Black, White, etc. 1 Never Married 2 Married þ 1 ☐ Yes 2 🌠 No If Yes, Give Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify: White Completed 3 Widowed 4 X Divorced Year or Dates the Medical Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) I Hygiene. College (1-4 or 5+) N/A Elementary/Seconday (0-12) 12 Homemaker Own Home permit. Page 1 and 2 should be filed w Department of Health and Mental Hygi Important: If item 27 is marked othe any injury or other traumatic event, i Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ρ Charles William Hicks Hilda Norsky 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Linda Bertazon/Daughter 14107 Robcaste Road Phoenix, MD 21131 20a. Method of Disposition 20b. Place of Disposition (Name of April 20, 2011 20c. Location - City or Town, State Dulaney Valley Memorial Gardens X Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) Timonium, MD 21. Signature of Funeral Flagle 10 W. Padonia Road Timonium, MD 21093 J. 23a. Part 1. Ente he disease, or o amplications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate shock, or heart failure. List only one cause on e Interval Between Immediate Cause (Final Onset and Death Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examiner Due to (or as a consequence of): been signed by the attending physician and should be detached for use as the burial-transit Cause (Disease or linjury that initiated events resulting in death) Last To the Hospital or Attending Physician: The law requires that the death certificate be exec Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 3 Ectopic pregnancy
4 Pregnant at time of death 5 Other (specify) 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?

1 Yes 2 No
9 Unknown Month Dav Year 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 6 Dudeter Completed 1 Yes 2 No 3 Probably 4 Tunknown Hypo, apiden 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 📉 No 24a. Was an has autopsy performed Yes 2 certificate eral Director: After this certific filled in by the funeral director, Be Was case referred to medical 26. Place of Death (Check only one) examiner? 2 No Hospital: 4 Nursing Home 5 Residence 6 Other: |은 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28c. Injury at work? 1 ☐ Yes 2 ☐ No Certificate: 28b. Time of 28d. Describe how injury occurred Natural 5 Pending iniury Accident
Suicide
Homicide Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined within 24 hours a

To the Funeral D

completed filled i Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) Maric ann 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 9 Schilling Road, Suite 102 Dr. Mark Lamos Hunt Valley, MD 21031 32. Registrar's Signature 31. Date filed (Month, Day, Year) APR 1 9 2011 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygieney 12486 Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ April 8, 2011 Helen M. Mayo 9:53 AM Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Gilchrist Hospice Care Baltimore Towson If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. Social Security Number **Funeral** 7. Age (In yrs. last birthday 8. Date of Birth 9. Birthplace (State or Foreign 1 🗆 M 2 🗓 F Months Days Nov. 4, 1930 **Director** 213-32-4649 Yrs 80 Washington D.C. Usual Residence of Decedent 28a-f show 10a. State 10b. County the Maryland Director 10c. City, Town or Location 10d. Inside City Limits notified MD 1 Tes 2 X No Baltimore Sparks 10e. Street and Number ō 10f. Zip Code be 10g. Citizen of What Country? Funeral "natural", or items 23a and 2 should be filed within 72 hours after death with 921 Upper Glencoe Road 21152 IISA 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, þ 1 Never Married 2 Married Black, White, etc. Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 X No Specify: 3 X Widowed 4 □ Divorced Completed Specify: White the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry h and Mental Hygiene.
If is marked other than "r traumatic event, the Med Elementary/Seconday (0-12) College (1-4 or 5+) Registered Nurse Medical Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ٩ Department of Health and Menta Important: If item 27 is marked any injury or other traumatic en once. C. William Hicks Monica Ε. McClernan 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1311 Glencoe Road Glencoe, MD 21152 George Mayo, VI/Son 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Page 1 20c. Location - City or Town, State April Date 9. 1 Burial 2 X Cremation 3 Removal from State 4 Donation 5 Other (Specify) Atlantic Crematory 2011 Glen Burnie, MD permit. 22. Name and Address of Facility
Lemmon Funeral Home of Dulaney Valley,
10 W. Padonia Road Timonium, MD 21093 Flaglé Michael 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final nset and 5 ath Physician NEUMONIA disease or condition Medical resulting in death) Due to (or as a consequence of): **Examiner** INFLAMMATORY LUNG DISCASE Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of) Examir burial-transi Cause (Disease or linjury that initiated events HEUMATOID ARTHRITIS attending physician and for use as the burial-tran Due to (or as a consequence of) resulting in death) Last Physician/Medical To the Hospital or Attending Physician: The law requires that the death certificate be Box 68760 the as IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death

4 Pregnant at time of death 23b. Was decedent pregnant. 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 mont Month Day Year ed by the a detached f 9 Unknown 9 Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. signed I 23e. Did tobacco use contribute to the cause of death? <u>\$</u> Records, DIABOTES MELLITUS been si Completed 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown er lension 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an cate has page 2 s certificate performed? 2 - No 1 🗌 Yes Yes 2 Division of Vital director, 25. Was case referred to medica Be 26. Place of Death (Check only one) examiner? 2 No Other: မ 1 Inpatient 2 ER/Outpatient 3 DOA After this 4 Nursing Home 5 Residence 6 Other (Specify) the funeral Certificate: 27. Manner eath 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred atural n 24 hours after death.

e Funeral Director: After the function by the function of the functin 5 Pending injury work? 1 ☐ Yes 2 ☐ No 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a, Certifier completed within 2 3 🗆 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29c. License number 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

2

State Registrar 31. Date filed (Month, Day, Year)

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32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygien For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2 Date of Death 3. Time of Death Month P(1) McCallum Physician/ Year Darry 7:35AM 20 Medical 4c. County of Death Baltimore 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Randlestown Examiner Season Hospice Birthplace (State or Foreign Country)
 MD If Under 1 Year If Under 24 Hrs. 7. Age (In yrs_last birthday) Social Security Number 218-72-0029 8. Date of Birth **Funeral** 1 **№** M 2 □ F Days Hours Min 9 / 2th 758 ar Yrs **Director** Usual Residence of Decedent or 28a-f show notified at 10c. City, Town or Location 10b. County 10d. Inside City Limits should be filed within 72 hours after death with the Maryland Director Baltimore MD N/A 1 Yes 2 No 10f. Zip Code 21 239 10e. Street and Number 10g. Citizen of What Country? P items 23a or ner must be n Funeral 1212 Walker Ave - Apt. C Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. "natural", or item ledical Examiner n 11. Marital Status 14. Race - American Indian, Armed Forces?

1 Yes 2 No
If Yes, Give
Year or Dates. African
Specify: Amer. þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: 3 ☐ Widowed 4 Bivorced Completed or other traumatic event, the Medical 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working Driver and Mental Hygiene. Bus Elementary/Seconday (0-12) College (1-4 or 5+) Be 18. Mother's Name (First, Middle, Maiden Surname) Charlotte Casterlow 17. Father's Name (First, Middle, Last) Jethro McCallaum 19a. Informant's Name/Relationship (Type, Print)
Jeffrey McCallum/Son 19b Mailing Address (Street and Number or Ryral Route Number, City or Town, State, Zip Code) 2512 Robb St., Balt., MD 21218 permit. Page 1 and 2 sl Department of Health al Important: If item 27 is any injury or other trau 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Balt., MD 4/19711 Bayview Crematory 1 Durial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) 22. Name and Address of FacilitHari P. Close F. Svs. PA 5126 Belair Rd, Balt., MD 21206-5105 . Signature of Funeral Service Licensee 23a. Part 1/Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock or heart failure. List only one cause on each line. Approximate Immediate Cause (Final End. Stage AIDS Onset and Death Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Examiner Due to (or as a consequence of): the burial-transit the Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events Due to (or as a consequence of): resulting in death) Last signed by the attending physician Physician/Medical Division of Vital Records, P.O. Box 68760 use as t IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months?

1 Yes 2 No Pregnant at time of death 1 Yes 2 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available 24a. Was an prior to completion of cause of death? performed? After this certificate 2 No 1 Yes To Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 🗹 No 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred 5 Pending 1 Natural 1 Yes Accident Suicide Investigation after death 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) within 24 hours a To the Funeral C 🗹 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month. Day, Year) 2 MS Raj apahrum. D D0057465 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) BIVO, GLENBRIME notion 6934 .5. Rajapakse 32. Registrar's State Registrar

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene, 12488 State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Judith C. Miller April 15 Day 2011 Year 2:25 P Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Manor Care-Potomac Potomac Montgomery 5. Social Security Number If Under 1 Year If Under 24 Hrs. **Funeral** 8. Date of Birth (Month, Day, Yo August 16, 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign 1 M 2 X F 85 Days Hours 578-28-4376 Months 1925 Washington, D.C Director Usual Residence of Decedent show Page 1 and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene. tant: If item 27 is marked other than "natural", or items 23a or 28a-f shoury or other traumatic event, the Medical Examiner must be notified at 10a. State 10b. County Director 10c. City, Town or Location 10d. Inside City Limits Maryland Montgomery Rockville 1 Yes 2 X No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 10500 Rockville Pike 20852 United States 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black, White, etc. Armed Forces? þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 No Specify: 3 X Widowed 4 Divorced Completed Specify: White 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry Elementary/Seconday (0-12) College (1-4 or 5+) Homemaker Own Home Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ဂ္ William Earl Clark Mary Harper 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mary M. Rice / Daughter 37 Hill Road Wilmington, Delaware 19806 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place)
Montgomery
Crematorium, Inc. permit. Page 1 a Department of H Important: If ite any injury or ot 20c. Location - City or Town, State Apri1^{Dat}20. 1 Burial 2 X Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Bethesda, Maryland 2011 Signature Funeral Service L 22. Name and Address of Facility
Robert A. Pumphrey Funeral Home, Bethesda-Chevy Chase,
7557 Wisconsin Avenue Bethesda, Maryland 20814 MO1607 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Immediate Cause (Final Endometrial Adenocarcinoma Physician/ Onset and Death disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of) Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-transit Cause (Disease or iinjury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) in the past 12 months?

1 Yes 2 No Pregnant at time of death Month signed by the a 9 Unknown Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ coronary artery disease Completed 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🔁 Unknown peen chronic kidney disease s certificate has build sirector, page 2 s 24a. Was an 24b. Were autopsy findings available prior to completion of cause of autopsy performed? Yes 2 No death? 25. Was case referred to medical director. Be 26. Place of Death (Check only one) examiner? Hospital: 1 ☐ Yes 2 🔼 No Other: ပ္ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Mursing Home 5 Residence 6 Other (Specify) this funeral 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28c. Injury at work? Certificate: 28b. Time of 28d. Describe how injury occurred 1 🛚 Natural 5 Pending injury 2 No after death Accident Investigation 1 Yes Suicide Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 24 hours Funeral Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier сотретер (Check the within 2 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) as OMAS D50534 4/16/2011 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Thomas Masterson 6858 Old Dominion Drive # 104 McLean, Virginia 22101 M.D.

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State Registrar 32. Registra s Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ lajors Month Year 18=19 PM Medical 201 4a. Facility Name (if not institution, give street and umber) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Agnes Hospita Baltimore 5. Social Security Number 6. Se: last birthday) If Under 1 Year If Under 24 Hrs. Funeral 8. Date of Birth Birthplace (State or Foreign Country) 1 🗆 M 2 🔎 Months Hours Min Director Usual Residence of Decedent or 28a-f show permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho any injury or other traumatic event, the Medical Examiner must be notified at any injury or other traumatic event, the Medical Examiner must be notified at once. 10a. State 10b. County Director 10c. City, Town or Location 10d. Inside City Limits MD 1 Yes 2 □ No 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? Completed by Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces?

1 Yes 2 No
If Yes, Give*
Year or Dates. Black, White, etc 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Black 3 Widowed 4 Divorced Specify: 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) onday (0-12) College (1-4 or 5+) Insurance <u>irance</u> Be Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ဂ္ ssie Carrination 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural-Route 2012 20b. Place of Disposition (Name of Burial 2 Cremation 3 Removal from State cemetery, crematory or other place 4 Donation 5 Other (Specify) 22. Name and Address of Facility 23a. Part (Er er medisease, or complications that caused the death. Do not enter the mode of dying, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate se (Final disease or indition Physician congestive Medical resulting in death) Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Physician/Medical Examiner Due to for as a consequence on Cause (Disease or linjury that initiated events Due to (or as a consequence of) resulting in death) Last Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months? Month Pregnant at time of death Dav Year Yes 2 No g Unknown 9 Unknown Division of Vital Records, P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ To the Hospital or Attending Physician: The law requires t within 24 hours after death.

To the Funeral Director. After the contract of the Funeral Director. 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an performed? Yes 2 No 1 Tes completed filled in by the funeral director. To Be 25. Was case referred to medical 26. Place of Death (Check only one) 1 ☐ Yes 2 No 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural injury 5 Pending work? 1 ☐ Yes 2 ☐ No. Accident Suicide Investigation Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
| Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check 29b. Signature and title of certifier D23494 April 132011 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Ming-Hsi 900 Baltimore, 21229 Ave 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar

ORIGINAL

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiener 12490 For State Registrar Certificate of Death Rea. No 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Edith Lucile Marlatt 2520 P.M Medical 4a. Facility Name (if not institution, give street and number Examiner City, Town, or Location of Death 4c. County of Death ALTIMORG HOSPITA N/A 5. Social Security Number Funeral 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs 8. Date of Birth 9. Birthplace (State or Foreign (Month, Day av 13 1 M 2 X F Months Days Hours Min. 214-36-8163 Director Maryland May 939 Usual Residence of Decedent 28a-f shov 10a. State 10b. County 10c. City, Town or Location Director 10d. Inside City Limits Examiner must be notified 1 Yes 2X No Baltimore Maryland Catonsville 5 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 23a Funeral 2024 Edmondson Avenue USA items 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces? 1 Yes 2 X No Black, White, etc. ò Completed by 1 Never Married 2 Married 72 hours after Baltimore, Maryland 21215-0036 permit. Page 1 and 2 should be filed within 72 hours afti. Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", any injury or other traumatic event, the Medical Exar any injury or other traumatic event, the Medical Exar any once. 1 ☐ Yes 2 X No Specify: If Yes, Give 3X Widowed 4 ☐ Divorced Specify: White Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Nurse Hospital Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Charles H. White Frances M. Roberts 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Jeffery Marlatt, Son 7546 Old Washington Road Woodbine, Maryland 21797 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State 1 🔀 Burial 2 🗆 Cremation 3 🗀 Removal from State cemetery, crematory or other place, 4 Donation 5 Other (Specify) 04/20/11 Garrison Forest Owings Mills, Maryland Signature of Funeral Service Licensee Thomas Gregor 22. Name and Address of Facility
MacNabb Funeral Home, P.A.
301 Frederick Road Catonsville, Maryland 21228 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one caused in each line. Immediate Cause (Final Onset and Death Physician. Artenoscleratio Vascular disease or condition resulting in death) ovensor Medical Due to (or as a consequence of Examiner Sequentially list conditions, Examiner Due to (or as a consequence of If ary, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events resulting in death) Last use as the burial-tran Due to (or as a consequence of): signed by the attending physician d be detached for use as the burial Physician/Medical To the Hospital or Attending Physician: The law requires that the death certificate be within 24 hours after death. Within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending nebysids 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?
1 Yes 2 No Pregnant at time of death Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Hypertension 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 s autonsy this certificate 2 No 1 Yes 2 No Yes funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? <u>_</u> Other: ER/Outpatient 3 DOA 1 Inpatient 2 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of injury 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending work? 1 ☐ Yes 2 ☐ No Accident Investigation Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 12053849 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 900 Catin Avenue Jergeson Itomital Agnes 31. Date filed (Month, Day, Year) State Registrar's Signat **APR 19** 2011 Registrar

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 11-02849 State of Maryland / Department of Health and Mental Hygiene Scott Hunt Morgan Certificate of Death 1- For State Registrar 1. Decedent's Name (First, Middle,Last) Physician/ **Medical Examiner** Morgan Scott Hunt 4a. Facility Name (if not institution, give street end number) 4b. City, Town, or Location of Death 7707 Edgewood Avenue Pasadena 7. Age (In yrs, last birthday) 6. Sex 5, Social Security Number **Funeral** Days Hours Months Director 1 M 2 F 229-96-4514 46 Usual Residence of Decedent 10c. City, Town or Location 10b. County Pasadena Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene.

aut: If them 27 is an arked other than "natural", or items 23s nr 28s-f shu rather transmatic event, the Medical Examiner must be notified at once. In where transmatic event, the Medical Examiner must be notified at once. Maryland | Anne Arundel Director 10f. Zip Code 10e. Street and Number 21122 7707 Edgewood Avenue Funeral 12. Was Decedent Ever in U.S. 11 Marital Status Armed Forces 1 Never Married 2 Married 1X Yes 2 during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+)

2. Date of Death Month Day April 14, 2011 1504 hrs 4c. County of Death Anne Arundel If Under 1 Year If Under 24Hrs. 8. Date of Birth (MM/DD/YYYY) 9. Birthplace (State or country Maryland 05/09/1964 10d. Inside City Limits 1 Yes 2 No 10g. Citizen of What Country? States United 14. Race - American Indian, Black, 13. Was Decedent of Hispanic Origin? (Specify Yes or No-White etc. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) White Wildowed 4 XDivorced If Yes, Give Year 1981-85 1 Yes 2 X No specify:

15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done Specify: 16b. Kind of Business/Industry Centric Business Systems Network Technician 12 18.Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Carolyn Basye Hopkins Thomas Be Robert 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 211 Lyons Road, Mertztown, Pennsylvania 19539 Amanda Morgan / Daughter 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, 20a. Method of Disposition crematory or other place) 1 Burial 2 XCremation 3 Removal from State 04/16/2011 Baltimore, Maryland Metro Crematory Inc. 4 Donation 5 Other Specify: 22. Name and Address of Facility Cremation Society of Maryland Taylor 21. Signature of Funeral Service Licensee Alyson K 299 Frederick Rd., Baltimore, Maryland 21228 alsoutingo Approximate Interval 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Retween Onset and failure, List only one cause on each line a Chronic Alcoholism Immediate Cause (Final disease or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, Due to (or as a consequence of): if any, leading to immediate Examiner cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical AMENDED UNPENDED 23c. If yes, outcome of pregnancy 23d Date of delivery IF FEMALE 23b. Was decedent pregnant in the 3 Ectopic pregnancy Day Fetal death 2 past 12 months? Pregnant at time of death 5 Other (Specify) 1 Yes 2 No 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 Yes 2 No 3 Probably 4 V Unknown <u>5</u> Completed 24b. Were autopsy findings available 24a. Was an prior to completion of cause of autopsy performed? death? ✓ Yes 2 No 2 No 1 🗸 Yes 26.Place of Death (Check only one) 25. Was case referred to medical BB Other Nursing Home 5 Residence 6 Other: Scene Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA 1 🗸 Yes 28c. Injury at Work? 28d. Describe how injury occurred 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 27. Manner of Death Certification 1 V Natural 1 Yes 2 No Pending 2 Accident Investigation 28f. Location (Street and Number or Rural Route Number, City 28e. Place of Injury - At home, farm, street, factory, office building, etc. 3 Suicide Could not be or Town, State) determined 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number April 15, 2011 O.C.M.E. wend 30. Name and address of person who completed cause of death (Item 23a) Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201 Laron Locke MD. Registrar's Signature

State Registrar

DHMH 17 Rev 1/2001

permit. Pages
Department o
Important: 1
injury nr nth

Physician

/Medical

Examiner

The law requires that the death certificate be executed

r this certificate has b al director, page 2 sho

After

Director:

Box 68760.

Records, P.O.

of Vital

ORIGINAL

DOME

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ April Joy Gladys McCoy 2011 11:55 PM Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Gilchrist Center Towson Baltimore Social Security Number 6. Sex If Under 1 Year | If Under 24 Hrs.
Months | Days | Hours | Min. 7. Age (In yrs, last birthday) 8. Date of Birth **Funeral** 9. Birthplace (State or Foreign 1 □ M 2🗓 F July 13,1923 Michigan Director 362-20-8610 Yrs 87 Usual Residence of Decedent 28a-f shov 10b. County 10a State items 23a or 28a-f shoner must be notified at 10c. City, Town or Location Director 10d. Inside City Limits 1 ☐ Yes 2🌠 No Marvland Queen Annes Stevensville 10e. Street and Number 10g. Citizen of What Country? Funeral 1002 Chesapeake Drive 21666 USA death v 11. Marital Status Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) item 27 is marked other than "natural", or iter other traumatic event, the Medical Examiner 14. Race - American Indian. Black, White, etc ģ 1 Never Married 2 Married 1 Yes 2 XNo If Yes, Give Maryland 21215-0036 1 ☐ Yes 2 XNo Specify. Completed 3 ¥ Widowed 4 □ Divorced Specify: White Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life, DO NOT use retired) Hygiene. Elementary/Seconday (0-12) 12 College (1-4 or 5+) should be filed with and Mental Hygier. Business Owner Self Employed Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ဂ William R. Carlson Gladys V. Wood 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 st Department of Health ar. Important: If item 27 is Roger Brent McCoy, 1404 Rainbow Drive Pasadena. Maryland 21122 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place, 20c. Location - City or Town. State 1 ☐ Burial 2 【XCremation 3 ☐ Removal from State 4 Donation 5 Other (Specify) Metro Crematory Inc. 04/18/11 Baltimore, Maryland 21. Signature of Funeral Service Licence Thomas Gregor 22. Name and Address of Facility Cremation Society Of Maryland, Inc. 299 Frederick Road Baltimore, Maryland 21228 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line Interval Between Immediate Cause (Final Onset and Death Pnysician/ disease or condition ducine Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of) the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of) physician Physician/Medical To the Hospital or Attending Physician: The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 as IF FEMALE: nse 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery for 3 Ectopic pregnancy in the past 12 months? Month Pregnant at time of death 5 Other (specify) Day Year 2 No signed by the a Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Completed 1 Yes 2 No 3 Probably 4 Tonknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page performed? certificate ! 1 ☐ Yes 2 ☐ No 1 Yes 2 No Be 25. Was case referred to medica 26. Place of Death (Check only one) examiner? Hospital Other: 2. No မ 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify) After this 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at work? 28d. Describe how injury occurred Matural injury 5 Pending s after death. Accident 1 Yes 2 No Investigation completed filled in by the Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one) 29b. Signature and title of certifier 29c. License number MD 16 7104 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Sui 10 4105 Bulti ruere PATHI KUMA

DHMH 17 Rev 7/2009

State Registrar 31. Date filed (Month, Day, Year)

Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2 Date of Death Physician/ Month 20/ Betty Ann Nixon 7:55 AM Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death ealth and Rehabilitation 19rford Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 □ M 2 💆 F NOV . 28 Months Days Hours Min. Pennsylvania 207-26-1377 78 Director 1932 Usual Residence of Decedent show 10a. State 10b, County 10c. City, Town or Location ortant. If item 27 is marked other than "natural", or items 23a or 28a-f sho injury or other traumatic event, the Medical Examiner must be notified at 10d. Inside City Limits Director 1 🗌 Yes 2 屎 No <u>Maryl</u>and Harford Havre de Grace 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21078 USA 247 A. Fountain St. Page 1 and 2 should be filed within 72 hours after death 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Forces?

1 Yes 2 X No Black, White, etc. 1 Never Married 2 Married δ Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify: If Yes, Give Year or Dates Specify: 3 ₩ Widowed 4 Divorced Completed White 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working d Mental Hygiene. marked other than life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Own Home Homemaker Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) and Mental F is marked o ည Saddie Elizabeth Markel John Richard Stephens 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) f Health a 800 Melody Ct., Edgewood, Maryland 21040 Billy T. Nixon / Son 20a, Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Department of P Important: If ite any injury or ot once, 1 ☐ Burial 2 ☐ Fremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) cemetery, crematory or other place Hilltop Service Corp. 4-20-11 Towson, Maryland 21. Signature of Funeral Service Licenses 22. Name and Address of Facility McComas Funeral Home, P.A. 1317 Cokesbury Road, Abingdon, Maryland 21009 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ 9 disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of): Exami physician and s the burial-transit Cause (Disease or in that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 attending IF FEMALE: nse 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ Į In the past 12 months? Pregnant at time of death signed by the a d be detached f 2 No Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🗷 Unknown Completed page 2 should peen s Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy within 24 hours after death.

To the Funeral Director. After this certificate I completed filled in by the funeral director, pag-1 ☐ Yes 2 ☐ No Yes 2 No 25. Was case referred to medical To the Hospital or Attending Physician: Be 26. Place of Death (Check only one) examiner?

1
Yes 2 X No Other: မ 4X Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 IDOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No 2 Accident
3 Suicide Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical VC Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifier Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 256545 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) BEL AIR RD #106. W. MACRHAIL

State Registrar

31. Date filed (Month, Day, Year,

APR 1 9 2011

615

32. Registrar's Signature

Kichard Chungsun Nam Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. **UNK UNK** amend #1 Brate BAWalland be a Riment of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle,Last) 2. Date of Death Physician/ 3. Time of Death Richard Chungsun Nam Month Modical Examiner Richard Chang Sun Nam 2311 hrs April 8, 2011 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death c. County of Death Prince George's Hospital Center Cheverly Prince George's If Under 1 Year If Under 24Hrs. 8. Date of Birth (MM/DD/YYYY) 9. Birthplace (State or Foreign S. KOrea 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** 214-80-9049 Director 1 M 2 F 69 August 27.1941 Country Usual Residence of Decedent 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits Maryland Prince Georges Mitchelville 28a-f show 1 Yes 2XXNo "natural", or items 23a or 28a-f sho Examioer must be ootified at once. within 72 hours after death with the Maryland Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country 10803 Arbor Way 20721 United States 11. Marital Status 12 Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, Armed Forces? 1 Never Married 2 W Married White, etc. 1 Yes _{Specify:} Asian 3 Widowed 4 Divorced If Yes, Give Year 1 Yes 2 X No specify: Ճ 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done 16b. Kind of Business/Industry Completed during most of working life. DO NOT use retired) Elementary/Secondary (0-12) **Baltimore**, MD 21215-0036 Self Employed Business Owner 17. Father's Name (First, Middle, Last) 18.Mother's Name (First, Middle, Maiden Surname) permit. Pages I and 2 should be filed to Department of Health and Mental Hyginportant: If item 27 is marked oth injury or other traumatic event, the Suk Kim Nam Be Mu Don Hwang 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Jinie Kang / Daughter 10803 Arbor Way, Mitchelville, Maryland 20721 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, 20c. Location - City or Town, State crematory or other place) 1 X Burial 2 Cremation 3 Removal from State Meadowridge Memorial April 12,2011 Elkridge, Maryland 4 Donation 5 Other Specify: 22. Name and Address of Facility Gary L. Kaufman Funeral Home, Inc. 21. Signature of Funeral Service License 7250 Washington Blvd., Elkridge, Maryland, 21075 Part I. Enter the disease, or complication that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Approximate Interval Physician failure. List only one cause on each line Between Onset and /Medical a. Multiple Injuries Death Examiner or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, Examiner if any, leading to immediate Due to (or as a consequence of): cause. Enter Underlying Cause (Disease or injury that initiated Due to (or as a consequence of): events resulting in death) Last and - transit Physician/Medical UNPENDED AMENDED ending physician use as the burial Hospital or Atteodiog Physiciao: The law requires that the death certificate be Box 68760. 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant in the 1 Live birth 2 Fetal death 3 Ectopic pregnancy Day Year past 12 months? Pregnant at time of death 5 Other (Specify) 1 Yes 2 No 9 Unknown for 9 Unknown signed by the a Division of Vital Records, P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ğ 1 Yes 2 No 3 Probably 4 Unknown Completed After this certificate has been funeral director, page 2 should 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? autopsy performed? Yes 2 No 2 No 1 Yes 25. Was case referred to medica 26.Place of Death (Check only one) Be examiner? Hospital: 1 Inpatient 2 ✓ ER/Outpatient 3 DOA Other Nursing Home 5 Residence 6 Other 1 🗸 Yes 28a. Date of Injury FOUND: 27. Manner of Death 28b. Time of Injury 28d. Describe how injury occurred 28c. Injury at Work? Certification: To the Hospital or America within 24 hours after death.

To the Fuoeral Director: A Subject assaulted 1 Natural FOUND: 5 Pending 1 ✓ Yes 2 No Apr 8, 2011 2235 hrs 2 ___ Accident Investigation 28e. Place of Injury - At home, farm, street, factory, office building, etc. 28f. Location (Street and Number or Rural Route Number, City 3 Suicide 6 Could not be or Town, State) 5439 Annapolis Rd., Bladensburg, MD determined (Specify) Minimart 4 V Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Wedical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29b. Signature and title-of certifier 29c. License number 29d. Date signed (Month, Day, Year)

01

State Registrar Melissa Brassell, MD

31. Date filed (Month, Day, Year)

APR 1 9 2011

30. Name and address of person who completed cause of death (item 23a)

OCME

Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201

O.C.M.E.

April 9, 2011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State
 Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month Year ARKER 10:50 AM 20 04 Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death <u>Levindale Geriatric and Rehab. Center</u> Baltimore If Under 1 Year | If Under 24 Hrs 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** (Month, Day, 1 - M 2 - F Months Days Hours Min **Director** 212-06-9986 Sept. 24,1966 Virginia Usual Residence of Decedent f show permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: I flem 27 is anarked other than "natural", or items 23a or 28a-f sho any injury or other traumatic event, the Medical Examinar must be notified at any injury or other traumatic event, the Medical Examinar must be notified at 10a. State 10b. County 10c. City. Town or Location 10d, Inside City Limits Director 1 Yes 2 No Maryland N/A Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21229 1305 N. Woodington Road Apt. USA 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Armed Forces?
1 ☐ Yes 2 🔀 No Black, White, etc. **S** 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: If Yes, Give Year or Dates 3 Widowed 4 Divorced Specify: Black Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) <u>12th grade</u> Unemployed N/A Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Harry Parker Helen Mims 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1305 N. <u> Trina Jackson/ Daughter</u> Woodington Road #4 Baltimore.MD 21229 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place, 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) Woodlawn Cemetery 4-22-2011 Woodlawn, MD 21. Signature of Mneral Service License 22, Name and Address of Facility Chatman—Harris Funeral Home 5240 Reisterstown Road Baltimore, MD 21215 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final ENCEPHALOPATHY Physician/ NOTIC disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Due to (or as a consequence of). Exami and I-transit Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of) resulting in death) Last attending physician a for use as the burial-Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months? Day Year Pregnant at time of death Yes 2 No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ Completed 1 Tes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available 24a. Was an prior to completion of cause of death? page 1 Yes 2 No 1 Yes 2 No Be 25. Was case referred to medical 26. Place of Death (Check only one) Hospital 1 Yes 2 No HOSPICE ၉ 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4. Nursing Home 5 ☐ Residence 6 ☐ Other (Spec 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28c. Injury at work? 28b. Time of ë 28d. Describe how injury occurred 1/ Natural injury 5 Pending Certificat 2 Accident
3 Suicide 1 Yes 2 No Investigation 6 Could not be within 24 hours after de To the Funeral Directo completed filled in by the 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined 28f. Location (Street and Number or Rural Route Number, Medica 29a, Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check 3 🗆 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one 29c. License number 29d. Date signed (Month, Day, Year) MYSICIAN 04-18-2011 D0064533

Registrar

DHMH 17 Rev 7/2009

State

BABATUNDE

31. Date filed (Month, Day, Year,

9 2011

2434 W. BELVEDERE

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) LEVINDALE

MI

CIERLATRIC

BALTIMORE

M) 21215

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Day PerKowsk 940 PM trancis 2011 Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death FRANKLIN SQUARE Baltimore Hospital Center Rosedale 5. Social Security Number 6. Sex 1 M 2 If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign Country) Maryland 7. Age (In yrs, last birthday) 8. Date of Birth **Funeral** Days 9-21-1937 Months Hours Min. 212-36-6622 Director 73 Usual Residence of Decedent 23a or 28a-f show 10b County 10a, State 10c. City, Town or Location Medical Examiner must be notified at 10d. Inside City Limits Director Md. Balto. 1 ☐ Yes 2 😾 No Nottingham Perkowski, Francis Maryland 21215-0036 10e. Street and Number 10f, Zip Code 10g. Citizen of What Country? Funeral 4135 Cliffvale Road USA Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian. Armed Forces? Black White etc. "natural", or þ 1 Never Married 2 Married 1 Yes 2 No Specify: Specify: 3 Widowed 4 Divorced Completed White 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) and Mental Hygiene. Is marked other than Elementary/Seconday (0-12) College (1-4 or 5+) the Homicide Detective Balto. City Police Dept. Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည and 2 should be Health and Ments Teddy H. Perkowski Frances D. Wujek 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Gloria Perkowski 4135 Cliffvale Road Spouse Nottingham, Md. 21236 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date permit. Page 1
Department of Important: If it any injury or o 1 Burial 2 Cremation 3 Removal from State cemetery, crematory or other place 4 ☐ Donation 5 ☐ Other (Specify) Holy Rosary 4-18-2011 Dundalk, Md. 21. Signature of Funeral Service License Schimunek FuneralHome 22. Name and Address of Facility 9705 Belair Road Nottingham, Md. 23a. Part 1. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. Let only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final ரிருsiciaா/ disease or condition resulting in death) HYDOXIG Medical Due to (o a a consequence of): Examiner Metastatic Lung Cancer Sequentially list conditions Examiner if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of): Cause (Disease or linjury i physician and s the burial-trans that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical or Attending Physician: The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 as attending IF FEMALE: nse 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) for in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day Pregnant at time of death sate has been signed by the page 2 should be detached a 🗌 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available 24a. Was an autopsy performed prior to completion of death? After this certificate has 1 Yes within 24 hours after death.

To the Funeral Director: After this certific completed filled in by the funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No Certificate: To 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Death 28a. Date of injury 28b. Time of 28c. Injury at 28d. Describe how injury occurred Natural (Month, Day, Year) 5 Pending work? 1 Yes 2 No Accident Investigation 3 ☐ Suicide 4 ☐ Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a, Certifier To the within 2 only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) adrien & 04/14/2011 00070158 Januar, MD, PhD 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 9000 FRanklin Square DR Balto md DRadrien Janvier 31. Date filed (Month, Day, Year) 32. Registrar's Signature State

Registrar

APR 19 2011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician : 25 PM Ethel_M._Pine 4 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Franklin Roseda Baltimore HOS pita Saluare 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 7. Age (In vrs. last birthday 8. Date of Birth (Month, Day, Year) Dec. 2, 1922 Birthplace (State or Foreign Country) **Funeral** Days Hours 1 □ M 2 🖵 F 217-12-9046 88 Director MD Usual Residence of Decedent 10b. County 10a. State 10c. City, Town or Location 10d. Inside City Limits item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examinational borrolling at Director MD Baltimore 1 ☐Yes 25 No Middle River 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 4016 Chesnut Road 21220 USA Funeral s 1 and 2 should be filed within 72 hours after deat of Health and Mental Hygiene. Item 27 is marked other than "natural", or items (12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married 1 □Yes 2 □No Maryland 21215-0036 If Yes, Give Year or Dates: 1 ☐Yes 2 ☐No Specify: à Specify: White 3 □ Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Customer Service Goodyear Tire 8th 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be James Novak ဂ Minnie Arnold 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Keefer M. Pine Jr. /son 4016 Chesnut Road Chesnut Road Balto. Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State permit. Pages 1 Department of I Important: If ite any injury or ot 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Bayview Crematory 4/19/11 4 Donation 5 ☐ Other (Specify) Baltimore MD 22. Name and Address of Facility 21. Signature of Fineral Se vice License 300 Mace Ave. Balto. MD Connelly Funeral Home of Essex 21221 23a. Part 1 Enter the disease, or con shock, or heart failure. List on plications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, one cause on each one. Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or as a consequence of): Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine or Attending Physician: The law requires that the death certificate be executed Oronary sician and burial-trans Due to (or as a consequence of) Box 68760. attending physician for use as the buria Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery for 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year P.O. 5 Other (specify) signed I Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed certificate | 2 12 No 1 □Yes 2 MNo 1 ☐ Yes : After this certification funeral director, p 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital: 1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 npatient Medical Certification: To 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 1 Natural 5 Pending death. investigation 1 ☐ Yes 2 ☐ No 2 Accident To the Hospital or Attend within 24 hours after death To the Funeral Director... the 6 Could not be 3 ☐ Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. completely (Check only one) 29b. Signature and title of Certifier 29d. Date signed (Month, Day, Year) 4-14-11 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

State Registrar Paz

Robert

31. Date filed (Month, Day, Year) APR 1 9 2011

INE

9000 Franklin Square Drive

Baltimore, MD 21237

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygienes For State Registrar Certificate of Death Reg. No. . Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ April Donato A. Pucciarella 2ÖÎ1 11:10P Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death 207 School Lane Linthicum Anne Arundel Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign Country) Pennsylvania Funeral 8. Date of Birth Month, Day, 1 🌠 M 2 🗆 F Months Days Hours **Director** 194-16-2688 85 May Usual Residence of Decedent ian "natural", or items 23a or 28a-f show Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location Director 10d. Inside City Limits 1 🗌 Yes 2 🔀 No Anne Arundel Linthicum Maryland 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 207 School Lane 21090 USA within 72 hours after death 11. Marital Status 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Forces?

1 X Yes 2 No
If Yes, Give 1943
Year or Dates. 1 Never Married 2X Married ş Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ▼ No Specify Specify: White Completed 3 Divorced 4 Divorced 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) permit. Page 1 and 2 should be filed within 7: Department of Health and Mental Hygiene. Important: If item 27 is marked other than any injury or other traumatic event, the Me Elementary/Seconday (0-12) College (1-4 or 5+) 12 Police Officer Baltimore City Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) <u>Angelo Pucciarella</u> Lucia Larderi 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Roseann Pucciarella, Wife 207 School Lane Linthicum, Maryland 21090 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date 1 ☐ Burial 2 【 Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) cemetery, crematory or other place, Metro Crematory Inc. : 04/18/11 Baltimore, Maryland emation Society Of Maryland, Inc. 9 Frederick Road Baltimore, Maryland 21228 21. Signature of Funeral Service License Thomas Gregor 23a. Part 1. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final CONGESTIVE HEART enysician/ disease or condition Medical resulting in death) Examiner ATHEROSCLEROTIC CARDIOVASCULAR DISEASE Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or iinjury that initiated events resulting in death) Last the attending physician and the for use as the bunal-tran Due to (or as a consequence of) Physician/Medical Division of Vital Records, P.O. Box 68760 JE FEMALE: 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day Year 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an performed 1 Yes 2 No 1 ☐ Yes 2 No Be 25. Was case referred to medical 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify, 2 No Hospital: မ 1 🔲 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 24 hours after death. Funeral Director: After this 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred Natural 5 Pendina 2 Accident
3 Suicide
4 Homicide 1 Yes 2 No Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 129807 181 of person who completed cause of death (Item 23a) (Type, Print) 30. Name and addre 1406 S. CPAIN HWY GLEN BURNIE IND SUITE 106 31. Date filed (Month, Day, Year) APR 19 State Registrar DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.											
		State of Maryland / Department of Health and Mental Hygiene									
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	Funeral Director			cial Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State							
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	1 and 2 should be filed within 72 hours after death with the Maryland if Health and Mental Hygiene. If Health mand Mental Hygiene. Item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at	Funeral Director	MD ANNE	trundel 100.0	ity, Town or Loc	inovel				10d. Inside City Limits 1 ☑ Yes 2 ☐ No	
	within 72 hours after death with the Maryland giene. er than "natural", or items 23a or 28a-f sho the Medical Examiner must be notified at the Medical Examiner must be notified at	eral D	10e. Street and Number	rsel Ro	L	10f. Zip Code	076		10g. Citizen of What C		
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21215-0036	2 hours after "natural", or edical Exami	ted by	1 Never Married 2 Married 3 Widowed 4 Divorced	1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates.		☐ Yes 2 🗔 No		,	Specify:	black	
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, Maryland	d 2 shou alth and n 27 is m er traum		19a, Informant's Name/Relationship (T	pe, Print) arren	19b. Mailin	g Address (Street a	nd Number or Ru	1 1	er, City or Town, State, Z	(ip Code)	
Baltimore,	permit. Page 1 and 2 st Department of Health a Important: If item 27 is any injury or other trai		20a. Method of Disposition 1		Place of Dispos cemetery, cree	sition (Name of natory or other place	e)	Date	20c. Location - City of	r Town, State	
ij	nit. Page artment o ortant: If injury or		4 Donation 5 Other (Specif	v)	<u>}} (K</u>	est	141	16/2011	Hanon	er, MD	
Ba	permil Depar Impor any in once.		21. Signature of Funeral Service Licens	kerul		Name and Addres	11	rowell	- Fund	MD 20794	
			23a. Part 1. Enter the disease, or com	olications that soused the dea				or respiratory ar	rest,	Approximate	
مدير	Physician/		shock, or heart failure. List only o Immediate Cause (Final disease or condition	79.	(000000		0000000			Interval Between Onset and Death	
Medical resulting in death) Examiner a. Frequency of: Due to (or as a consequence of):									/ HOUR		
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The part of the pa							rmed? death?	death?			
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on	ending sath. or: Afte he fun	ficat	1 Natural 5 Pending 2 Accident Investigation	(Month, Day, Year) injury work? M 1 □ Yes 2 □ No				200 Social New Highly Coolings			
ivisi	or Atta after de Directo in by t	Certificate:	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)					28f. Location (Street and Number or Rural Route Number, City or Town, State)		
Ω	To the Hospital or Attending Physician: The law within 24 hours after death. To the Funeral Director: After this certificate has completed filled in by the funeral director, page 2 of the physician of the funeral director, page 2 of the funeral director, page 2 of the funeral director, page 2 of the funeral director, page 2 of the funeral director, page 2 of the funeral director, page 2 of the funeral director, page 2 of the funeral director, page 2 of the funeral director d	Medical	29a. Certifier (Check 29a. Medical Examiner: On the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check 20a. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner state.								
The part of the pa								ace, and due to the cause(s) and manner as stated.			
				200				APRIL II, 2011			
	30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Terrorde T. Swydsch m D. 900 Sou Thi CATON AVENUE BALTIMORE, MARY										
			Jenne I. SN	VDER MD 900S	SOUTH C	ATON AU	ENLIE B	ALTIMO	RE MARYL	9ND 21229	
- 1/2	Stat Registra		31. Date filed (Month, Day, Year) APR 1 9 2011	32. Registrar's Signa	ture						

Parker, William

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2500 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ ens 255A M AMES Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death 308 Cheddington Road Linthicum Anne Arundel Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 03–22–1938 7. Age (In vrs. last birthday **Funeral** 9. Birthplace (State or Foreign Birtnpia. Country) MD 1**x**xM 2 □ F Min. Director 219-34-0191 Yrs. Usual Residence of Decedent 28a-f show 10a. State 10b. County with the Maryland Examiner must be notified at 10c. City. Town or Location Director 10d. Inside City Limits 1 ☐ Yes 2 🕱 No MD Anne Arundel Linthicum 10e. Street and Number ò 10f. Zip Code 10g. Citizen of What Country? Funeral or items 23a 308 Cheddington Road 21090 United States 72 hours after death 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian. Armed Forces? 1955 Black, White, etc. þ 1 Never Married 2XX Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 Yes 2 X No Specify. 1959 "natural", Completed 3 Widowed 4 Divorced Specify: White event, the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) and Mental Hygiene. Page 1 and 2 should be filed within ment of Health and Mental Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) 10 Foreman permit. Page 1 and 2 should be filed wit Department of Health and Mental Hygle. Important: If item 27 is marked other i any injury or other traumatic event, th Chemical Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ဂ Unavailable Unavailable 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Wanda Peters - wife 308 Cheddington Road, Linthicum, Maryland 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 🔀 Burial 2 🗆 Cremation 3 🗆 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Meadowridge Mem Park | 04-13-2011 Elkridge, Maryland Sign 22. Name and Address of Facility Gary L. Kaufman Funeral Home at MMP, Inc, 7250 Wash Blvd, Elkridge, MD 21075 Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Ph sician/ disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions if any, leading to him radiate cause. Enter Underlying Examiner Due to (or as a consequence of, Cause (Disease or linjury that initiated events resulting in death) Last Hospital or Attending Physician: The law requires that the death certificate be execute been signed by the attending physician and should be detached for use as the burial-trar Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death
9 Unknown 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?
1 Yes 2 No Month Year Day 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy within 24 hours after death.

To the Funeral Director: After this certificate 1 Yes 2 No Yes 2 No 25. Was case referred to medical Certificate: To Be 26. Place of Death (Check only one) examiner? 1 🗌 Yes Other: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DQA 4 Nursing Home 5 Residence 6 Other (Specify funeral 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Natural Accident 5 Pending injury work? 1 ☐ Yes 2 ☐ No Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) pleted filled in by 4 Homicide 28f. Location (Street and Number or Rural Route Number, determined Medical 12 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier only one Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title. 29c. License number 30. Name and address of pe

Registrar

31. Date filed (Month, Day, Year, APR 1 9 2011

XI

son who completed cause of death (Item 23a